A Healthier Bedfordshire
working with you for life

Delivering our Strategic Plan 2009-2013

December 2009
# Table Of Contents

1  VISION..................................................................................................................................9
   1.1  OUR ONE AIM ..................................................................................................................9
   1.2  OUR FOUR STRATEGIC GOALS ....................................................................................9
   1.3  OUR EIGHT PLANS .........................................................................................................11
   1.4  OUR THREE STRATEGIC PRIORITIES .........................................................................12
   1.5  OUR VALUES ..................................................................................................................15

2  BEDFORDSHIRE TODAY AND IN THE FUTURE .................................................................15
   2.1  POPULATION ..................................................................................................................16
   2.2  BEDFORDSHIRE’S AGEING POPULATION ......................................................................19
   2.3  ETHNICITY .......................................................................................................................20
   2.4  DEPRIVATION AND CURRENT HEALTH INEQUALITIES ...........................................21
   2.5  COMPARISON OF KEY HEALTH INDICATORS .............................................................25
   2.6  FUTURE HEALTH INEQUALITIES ..................................................................................28
   2.7  IMPACT OF INCREASING TECHNOLOGY ....................................................................29
   2.8  RISING EXPECTATIONS AND THE CHALLENGES WE FACE ....................................29

3  INSIGHTS OF PATIENTS, PUBLIC, CLINICIANS AND PARTNERS ....................................33
   3.1  DEVELOPING OUR STRATEGY ......................................................................................33
   3.2  PATIENT AND PUBLIC ENGAGEMENT ..........................................................................36
      3.2.1  Staying Healthy .......................................................................................................36
      3.2.2  Mental Health ..........................................................................................................37
      3.2.3  Maternity and New Born .........................................................................................38
      3.2.4  Children’s Services ..................................................................................................38
      3.2.5  Planned Care ............................................................................................................39
      3.2.6  Acute Care ...............................................................................................................40
      3.2.7  Long Term Conditions ............................................................................................41
      3.2.8  End of Life Care ......................................................................................................42
   3.3  THE NHS CONSTITUTION ..............................................................................................42
   3.4  PATIENT SURVEYS ........................................................................................................44
   3.5  BEDFORD HOSPITAL 2008/09 .......................................................................................45
   3.6  BEDFORDSHIRE AND LUTON COMMUNITY NHS TRUST 2008/09 ............................47
   3.7  LUTON AND DUNSTABLE NHS FOUNDATION TRUST ...........................................49
   3.8  WORLD CLASS COMMISSIONING PATIENT EXPERIENCE METRIC ..........................50
   3.9  PALS ENQUIRIES AND COMPLAINTS .......................................................................51
   3.10  COMMENT CARDS ......................................................................................................52
   3.11  LISTENING TO AND SUPPORTING CARERS ...............................................................52
   3.12  DEVELOPING DELIVERY AND IMPROVING PRACTICE IN ASSESSMENT ..............53
   3.13  ONGOING CLINICAL ENGAGEMENT AND CLINICAL LEADERSHIP .......................53
   3.14  ENGAGEMENT WITH OUR PARTNERS .......................................................................55

4.  SO WHAT DO WE NEED TO DO? .......................................................................................55
   4.1  INVESTING A GREATER PROPORTION OF OUR MONEY INTO PREVENTION ..............56
   4.2  CREATING EFFECTIVE SUPPORT IN LOCAL COMMUNITIES ...................................57
   4.3  ENSURING THAT THE PEOPLE OF BEDFORDSHIRE HAVE MORE CHOICE AND CONVENIENCE .. 58

5  EXISTING TARGETS, LOCAL AND NATIONAL PRIORITIES ..........................................59
   5.1  BEDFORDSHIRE’S LOCAL AREA AGREEMENT 2008-2011 .........................................61

6  OUR TRACK RECORD OF SUCCESS .................................................................................62
   6.1  FINANCIAL TURNAROUND ............................................................................................62
   6.2  1CALL: REDUCING UNNECESSARY EMERGENCY ADMISSIONS ..................................62
   6.3  IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) ..................................63
6.4. IMPROVING COMMUNITY HEALTH SERVICES .............................................................. 63
6.5. IMPROVING ACCESS TO GENERAL PRACTICE ........................................................... 63
6.6. IMPROVING ACCESS TO DENTISTS ............................................................................ 63
6.7. IMPROVING MENTAL HEALTH AND WELL BEING .................................................... 64
6.8. IMPROVING ACCESS TO LOCAL CARE ...................................................................... 64

7. PROVIDER LANDSCAPE ........................................................................................................ 65

7.1. DRIVING UP QUALITY AND SAFETY ............................................................................ 67
7.2. RELATIONSHIP WITH OTHER COMMISSIONERS ....................................................... 70
7.3. ACUTE HOSPITAL PROVIDERS .................................................................................... 70
7.4. ACCESS TO ACUTE AND SPECIALIST SERVICES ...................................................... 71
7.5. STRATEGIC PRIORITIES AND IMPLICATIONS FOR THE ACUTE MARKET ................. 72
7.6. COMMUNITY SERVICES ............................................................................................... 72
7.7. PHARMACY PROVIDER LANDSCAPE .......................................................................... 75
7.8. PHARMACY ACCESS AND CHOICE — MARKET STIMULATION ................................. 77
7.9. DENTISTRY .................................................................................................................. 77
7.10. ‘HEAT’ MAPPING OF GEOGRAPHICAL DENTAL ACCESS ............................................ 79
7.11. COMMUNITY HEALTH SERVICES ............................................................................. 81
7.12. INDEPENDENT CARE PROVIDERS (NURSING HOMES) ............................................ 82
7.13. MENTAL HEALTH SERVICES ...................................................................................... 83
7.14. DEVELOPING THE LOCAL MARKET .......................................................................... 84

8 IMPACT OF CHALLENGES ON OUR FUTURE FINANCES .................................................... 85

8.1. CURRENT FINANCIAL SITUATION ................................................................................. 85
8.2. FUTURE POSITION ......................................................................................................... 86
8.3. ALLOCATION OF ADDITIONAL RESOURCES .............................................................. 88
8.4. STRATEGIC THEMES .................................................................................................... 89
8.5. RESHAPING THE LANDSCAPE THROUGH PROGRAMME BUDGETS ............................. 91
8.6. CAPITAL INVESTMENT PLAN ....................................................................................... 92

9 DELIVERING OUR STRATEGY ........................................................................................................ 93

9.1 OVERVIEW ..................................................................................................................... 94
9.2 LINKS TO UNDERPINNING PLANS .............................................................................. 94
9.3 STRATEGIC INITIATIVE SUMMARY PLANS ................................................................ 96
  9.3.1 Staying Healthy ........................................................................................................... 96
  9.3.2 Mental Health and Learning Disabilities .................................................................. 96
  9.3.3 Maternity and New Born ............................................................................................ 98
  9.3.4 Children’s Services .................................................................................................... 99
  9.3.5 Planned Care, including Dental ............................................................................... 100
  9.3.6 Acute Care ............................................................................................................... 101
  9.3.7 Long Term Conditions ............................................................................................. 102
  9.3.8 End of Life Care ...................................................................................................... 103
9.4 HOW WE WILL MEASURE AND MONITOR PROGRESS .............................................. 104
9.5 KEY RISKS AND MITIGATING ACTIONS ....................................................................... 105
  9.5.1 Most Critical Executive / PCT Level Risks ............................................................... 106
  9.5.2 Most Critical Initiative Risks .................................................................................. 106
9.6 LINKS TO UNDERPINNING PLANS ............................................................................. 108
  9.6.1 Communications and Public Engagement ............................................................... 108
  9.6.2 Workforce ............................................................................................................... 109
  9.6.3 Information Technology .......................................................................................... 114
  9.6.4 Capital and Estates ................................................................................................ 115
9.7 CHANGE MANAGEMENT ............................................................................................... 119

10 APPENDICES ...................................................................................................................... 121

A. INITIATIVES ..................................................................................................................... 121
B. TOWARDS THE BEST TOGETHER, MENTAL HEALTH IMPLEMENTATION PLAN ....... 121
C. OPERATIONAL PLAN ..................................................................................................... 121
D. JSNA ................................................................................................................................. 121
List of Tables and Figures

Figure 1 - Our eight plans across life pathway from birth to end of life .................................................. 11
Table 1 – Darzi pathways and strategic priorities mapped against health outcomes .................................. 13
Table 2 – WCC outcome measures ........................................................................................................... 14
Table 3 – Population summary (mid year 2009 forecast) ......................................................................... 17
Table 4 – Bedfordshire – male population estimates and projections 2008 to 2015 ................................. 17
Table 5 – Bedfordshire – female population estimates and projections 2008 to 2015 ............................. 18
Figure 3 – Predicted age structure, males 2009, 2012 and 2015 ................................................................. 18
Figure 4 – Predicted age structure, females 2009, 2012 and 2015 ............................................................... 19
Table 6 – Predicted population changes in Bedfordshire ......................................................................... 19
Table 7 - Ethnic origin in Bedfordshire and Districts (percentages) ............................................................ 21
Figure 6 - IMD 2007 score at LSOA level ................................................................................................. 23
Figure 7 - Life expectancy at MSOA level ................................................................................................. 24
Figure 8 - Key health indicators .............................................................................................................. 25
Figure 10 - Bedford and Marston Vale growth areas (Renaissance Bedford) ......................................... 32
Figure 11 – Potential areas for development: Luton and South Bedfordshire ........................................ 32
Table 8 – Patient survey results 2004-2008 ............................................................................................... 45
Table 9 – Bedford Hospital Health Check rating ..................................................................................... 45
Table 10 – Bedford Hospital Health Check rating .................................................................................... 46
Table 11 – Bedford Hospital summary patient survey scores 2009 ............................................................ 46
Table 12 – Bedford and Luton Community NHS Trust Health Check rating ........................................... 47
Table 13 – Bedford and Luton Community NHS Trust Health Check rating ........................................... 47
Table 14 – BLPT summary inpatient survey scores 2009 ...................................................................... 48
Table 16 – Luton and Dunstable NHS Foundation Trust Health Check rating ........................................ 49
Table 17 – Luton and Dunstable NHS Foundation Trust Health Check rating ........................................ 49
Table 18 – Luton and Dunstable Hospital patient survey scores 2009 ....................................................... 50
Table 19 – CQC ratings 2009 and previous years’ HCC ratings ............................................................... 69
Figure 12 - Acute care availability of PCTs in East of England ............................................................... 71
Figure 13 - GP practices mapped over population density .................................................................... 73
Table 20 - Patients treated in last two years ............................................................................................. 77
Table 21 – Percentage of patients treated locally, regionally and nationally in previous 24 months, for the years ending 31 March 2006, 2007 and 2009 ............................................................... 78
Figure 15 - Patients seen in Bedfordshire, East of England and England ................................................ 78
Figure 16 - Population per dentist ........................................................................................................... 79
Figure 17 - Population within 5 miles of a dentist .................................................................................. 80
Figure 18 - Population within 8 miles of a dentist .................................................................................. 80
Figure 19 - Population within 12 miles of a dentist ................................................................................ 80
Figure 20 - Population within 15 and 30 minutes travel time of a dentist .............................................. 80
Table 22 - Realistic case financial projection ............................................................................................ 87
Table 23 - Worst case financial projection ............................................................................................... 87
Figure 21 - Bridge diagram of additional spent between 2008/09 and 2013/14 ....................................... 88
Table 24 - Funding across 8 strategic priorities ....................................................................................... 90
Table 25 - Spend across 23 programme budgets ..................................................................................... 92
Table 26 - Block capital projection .......................................................................................................... 93
Table 27 - Initiatives linked to goals .......................................................................................................... 94
Table 28 - Initiatives linked to pledges ..................................................................................................... 95
Table 29 – Projects under way mapped against success measures ......................................................... 95
Table 30 - Measures of progress against initiatives ............................................................................... 104
Table 31 – Most critical executive / PCT level risks .............................................................................. 106
Table 32 – Most critical initiative risks ................................................................................................... 106
Table 33 - Workforce requirements at initiative level ............................................................................. 109
Table 34 - Workforce requirements at initiative level ............................................................................. 111
Foreword

Bedfordshire is a wonderful place to live and the people of Bedfordshire deserve better health and a world class health service. Our goal is to make sure that this becomes a reality.

_A Healthier Bedfordshire_ paints a clear picture of our health and health services today, the challenges we face, where we want to be over the next five years and how we plan to get there.

The challenges are great.

Demand for healthcare will keep increasing as our population grows and more people live longer.

Health inequalities remain stubbornly persistent. It is not right or fair that people in some parts of Bedfordshire can expect to live up to ten years less than those in the most affluent areas. We must change this.

People rightly have higher expectations of their NHS and we have to rise to meet those expectations.

_A Healthier Bedfordshire_ addresses these challenges.

We have set ourselves ambitious goals and we will not achieve them by doing more of the same.

Our strategy is about change. We need to change how healthcare is delivered, with more services provided safely and effectively in local communities, closer to home. That will free our hospitals to concentrate on more complex care. Our strategy sets out how we will shift investment, over time, from hospitals to communities to make this happen.

Our strategy is also about partnerships. We will work more closely with our partners to plan and deliver services. We will work with our residents to support and empower communities and individuals to improve their health and well-being.

At the heart of our strategy is the prize of securing a healthier Bedfordshire for all, helping people to enjoy a longer life and a better quality of life. Together we can do it.
Sarah Boulton
Chair, NHS Bedfordshire

Andrew Morgan
Chief Executive, NHS Bedfordshire

Approved By Board 21 January 2009
Preface

The overall health of the people in Bedfordshire is better than the national average; additional progress is required to meet the higher East of England average life expectancy. However, across Bedfordshire there are important inequalities in health between different geographical areas and marginalised groups. We have an ageing population. As our population ages more people will suffer from long term conditions and will require more support to maintain healthy, independent lives. Bedfordshire is an area targeted for new housing developments. The resulting increase in population is unlikely to be matched immediately by a corresponding increase in central funding.

Our aim:

As the leader of the NHS in Bedfordshire, we will optimise the use of resources, in the context of a growing and ageing population, to deliver our goals to:

1. Improve the health and wellbeing of the population in Bedfordshire and its local communities in a fair and transparent way.

2. Reduce unfairness in health and reduce health inequalities.

3. Ensure a better healthcare experience for the population of Bedfordshire.

4. Ensure that the people of Bedfordshire have more choice and access to high quality, safe, clinically and cost effective local health services.

Three strategic priorities will drive our implementation plans

1. Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).

2. Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean
   • Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it.
   • Ensuring shorter waiting times for treatment.
   • Respecting the wishes of patients about their care from birth to the end of their life.

3. Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.
Achieving our goals will require change across all services, covering the life pathway from birth to end of life. Clinical and public engagement have informed implementation plans setting out the change required across these eight areas:

- Staying healthy
- Mental health (including drug users) and learning disability
- Maternity and new born
- Children’s services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire’s strategy will require:

- Increased efficiency savings.
- Rigorous fair and transparent prioritisation.
- Selling assets which are not fit for purpose and reinvesting the proceeds in appropriate, modern facilities.
- Spend on acute and specialist services currently consumes circa 45% (£229m) of our income, whilst spend on out of hospital services consumes 55% (£276m). This balance will need to change.
- NHS Bedfordshire’s income will rise from a current £505.6m in 2008/09 to £644.2m in 2013/14. Our investment plans demonstrate how this will be spent.
- Of this increase in income of circa £139m, 16% (£23m) will be spent on acute and specialist services and the remaining 84% (£116m) will be spent on out of hospital services.
- This represents a significant shift in the focus of our spend by 2013/14. The balance of spend shifts to 39% (£252m) on acute and specialist services and 61% (£392m) on out of hospital services.
- The delivery of our strategy will require changes to the role and ways of working of existing hospitals.
1 Vision

Our strategy is the culmination of two years’ work, listening to local people from all walks of life in consultations, partnership boards, focus groups, stakeholder events, in meetings, in GP practice waiting rooms, through surveys. We have reviewed best practice, looked at the clinical evidence, assessed the health needs of all our communities and taken on board the views and advice of clinical experts.

1.1 Our One Aim

As the leader of the NHS in Bedfordshire, we will optimise the use of resources, in the context of a growing and ageing population, to deliver our goals.

1.2 Our Four Strategic Goals

We have developed four goals that broadly describe our aspirations for a healthier Bedfordshire.

(1) To improve the health and wellbeing of the population in Bedfordshire and its local communities in a fair and transparent way

A key aspiration for NHS Bedfordshire is to increase life expectancy for its residents and we are working hard with our partners to achieve set targets. To improve life expectancy in Bedfordshire, we must tackle the main causes of premature death, cancer, CHD/stroke, accidents, suicide and liver disease. These are also identified as priorities nationally and regionally.

Both the NHS in the East of England and NHS Bedfordshire are committed to placing as much emphasis on improving health and wellbeing as on providing treatment and developing and strengthening prevention programmes so that they are the best in England.

The aspiration to improve health and well-being in Bedfordshire and decrease health inequalities is shared by all key partners across Bedfordshire. In Bedfordshire, this shared aspiration is currently articulated in Bedfordshire’s Sustainable Community Strategy. Over the last year through the Local Area Agreement, partners have agreed 23 priorities where change is required in Bedfordshire to take forward our shared strategy. NHS Bedfordshire will lead on reduction of smoking, decreasing childhood obesity, improving life expectancy and reducing health inequalities. A local priority is increasing the percentage of drug users engaged with treatment. These relate to our world class commissioning metrics.
(2) To reduce unfairness in health and reduce health inequalities

There are significant differences in health outcomes in Bedfordshire that are related to deprivation. It is not right that there is a ten year difference in life expectancy between different parts of the county. Inequalities are driven by differences in high risk lifestyle behaviours, such as smoking, obesity and physical activity, variations in access to healthcare and by wider socio-economic factors such as poverty, housing, employment and the built environment.

Inequalities do not relate only to deprivation and where you live; some members of our society experience inequalities more than others. There are complex reasons why people can become marginalised and our strategy seeks to address inequalities wherever they happen and whatever their cause.

NHS Bedfordshire has put in place specific and ambitious targets to reduce health inequalities. Our headline pledges are to ensure enhanced targets and uptake of services in the 20% most deprived areas and for vulnerable groups, with a focus on:

- Early access to antenatal care – increase in smoking in pregnancy quitters, promote healthy weight, increase breastfeeding rates
- Primary and secondary prevention – including smoking, cardiac and pulmonary rehabilitation
- Flu immunisation uptake and winter warmth payments.

(3) To ensure a better healthcare experience for the population of Bedfordshire

The views of service users must play a key part in our commissioning decisions. We cannot hope to commission world class healthcare services without understanding what is important to patients, what their current experiences are when they use the NHS and what we need to aim for.

Improving patients’ experiences will mean we are improving health services and also improving people’s health. We must take account not just of health needs, but of people’s preferences and aspirations. There are many ways we engage with patients as set out elsewhere in this document and we need to build on this, making sure that their views help us to drive improvement across all services, making the best use of our resources.

(4) To ensure that the people of Bedfordshire have more choice and access to high quality, safe, clinically and cost effective local health services

New ways of working and advances in treatments and associated technologies is enabling us to deliver an increasing range of healthcare services closer to home, in local communities. We know from national and local surveys that patients welcome more choice about where and when they are treated, through services that are
designed and delivered around their lives rather than the other way round. Delivery of our strategy will see new services developed that will reduce the reliance on acute hospitals.

1.3 Our Eight Plans

Achieving our goals will require change across all services, covering the life pathway, from birth to end of life. Clinical and public engagement has informed implementation plans setting out the change required across these eight areas:

- Staying healthy
- Mental health (including drug users) and learning disability
- Maternity and new born
- Children’s services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

In keeping with the case for, and principles of, change, the working groups link together a whole service, whole life and vision for NHS Bedfordshire.

NHS Bedfordshire has identified some quick wins for achievement. These include:

- Change4Life – focusing on childhood obesity, promoting healthy eating and increased activity
- Developing health trainer programmes for vulnerable communities, with an initial focus on primary prevention
- Implementing Improved Access to Psychological Therapies
- Promoting Staying Healthy in the Workplace to surrounding employers to influence and lead change
- Implementation of screening programmes for 40-74 year olds.

Figure 1 - Our eight plans across life pathway from birth to end of life
1.4 Our Three Strategic Priorities

Three strategic priorities have clearly emerged through the process of translating our strategic goals into the detailed plans that will deliver them. These can be thought of as ‘golden threads’ running through each of our eight implementation plans.

1. Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).

2. Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean:

   - Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it
   - Ensuring shorter waiting times for treatment
   - Respecting the wishes of patients about their care from birth to the end of their life.

3. Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire’s strategy will require:

   - Increased efficiency savings.
   - Rigorous, fair and transparent prioritisation.
   - Selling assets that are not fit for purpose and reinvesting the proceeds in appropriate modern facilities.
<table>
<thead>
<tr>
<th>Darzi Pathways</th>
<th>Strategic Priorities</th>
<th>Strategic Priorities</th>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTION</strong></td>
<td>Invest a greater proportion of our money into prevention</td>
<td>LOCAL</td>
<td>Creating effective support in local communities to reduce the reliance on hospital care</td>
</tr>
<tr>
<td><strong>LOCAL</strong></td>
<td>Creating effective support in local communities to reduce the reliance on hospital care</td>
<td><strong>CHOICE</strong></td>
<td>Offering more choice and convenience through care closer to home</td>
</tr>
</tbody>
</table>

**Staying Healthy**
- Increase smoking quitters (1, 2, 4, 5)
- Halt then reduce childhood obesity (1, 2, 6)
- Reduce teenage conception rates (3)
- Reduce substance misuse (11)
- Offender health (3, 11)

**Mental Health (including drug users) and Learning Disabilities**
- IAPT (4, 7, 8)
- Implement dementia strategy (4, 7, 8)
- CMHT redesign (4, 7, 8)
- Suicide strategy (1, 2, 4, 7, 8)
- LD healthcare for all (1, 2, 3, 4, 7, 8)

**Maternity and Newborn**
- Early access to antenatal care (3, 5, 6, 7)
- Reduction of smoking when pregnant (5)

**Children’s Services**
- Reduce substance misuse (3, 11)
- CAMH early intervention team
- HCP (0-19 teams) (3, 5, 6)

**Planned Care**
- Extended GP hours (8)
- Introduce health checks (1, 2, 3, 7)
- Implement national screening programmes (1, 2, 7)
- Reducing GP referrals (8)

**Acute Care**
- Reduce ambulance frequent fliers (7)
- Introduce new three digit number (7)

**Long Term Conditions**
- New diabetes service (1, 2, 3, 4, 7)
- Review COPD model of care (1, 2, 3, 4, 7)
- Review of asthma model of care (1, 2, 3, 4, 7)
- Stroke prevention (1, 2, 5)
- Management of osteoporosis and prevention of falls (1, 2, 4, 7)

**End of Life**
- Education and training
- Preventing acute admissions (4, 7)

**Table 1 – Darzi pathways and strategic priorities mapped against health outcomes**
## WCC OUTCOME MEASURES

The table below identifies the 11 outcome measures identified within the NHS Bedfordshire Strategic Plan and linked to World Class Commissioning requirements.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>2008/09 position</th>
<th>2009/10 target</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Life expectancy</td>
<td>Male mortality rate per 100,000 population</td>
<td>653</td>
<td>610</td>
<td>564 Qtr 1</td>
</tr>
<tr>
<td></td>
<td>Female mortality rate per 100,000 population</td>
<td>485</td>
<td>450</td>
<td>432 Qtr 1</td>
</tr>
<tr>
<td>Increase life expectancy in the poorest 20% of our communities</td>
<td>Male mortality rate in 20% most deprived communities rate per 100,000 population</td>
<td>724</td>
<td></td>
<td>750 Qtr 1</td>
</tr>
<tr>
<td></td>
<td>Female mortality rate in 20% most deprived communities rate per 100,000 population</td>
<td>571</td>
<td></td>
<td>553 Qtr 1</td>
</tr>
<tr>
<td>Improve the lives of those with long term illness</td>
<td>Ranking of NHS Bedfordshire’s position nationally compared to all PCTs in England</td>
<td>34th out of 152</td>
<td>15th out of 152</td>
<td>Qtr 1 available in mid November</td>
</tr>
<tr>
<td>Increase the numbers of smoking quitters</td>
<td>Number of people who have stopped smoking for four consecutive weeks</td>
<td>2707</td>
<td>2600</td>
<td>917 August unvalidated</td>
</tr>
<tr>
<td>Halt the rise in obese children and then seek to reduce it</td>
<td>Percentage of obese children in school year 6</td>
<td>15.1%</td>
<td>15%</td>
<td>Available in Dec 2009</td>
</tr>
<tr>
<td>Deliver year on year improvements in patient experience</td>
<td>NHS Bedfordshire score taken from the National Survey of Local Health Services 2008</td>
<td>78 out of 100</td>
<td>82 out of 100</td>
<td>Annual Patient Survey</td>
</tr>
<tr>
<td>Ensure GP practices improve access and become more responsive to the needs of all patients</td>
<td>NHS Bedfordshire results of GP Patient Survey 2008/09</td>
<td>79% satisfaction</td>
<td>90%</td>
<td>Moving to 1/4ly survey. Qtr 1 not yet available</td>
</tr>
<tr>
<td>Ensure NHS primary dental services are available to all who need them</td>
<td>% of people receiving NHS primary dental services</td>
<td>54%</td>
<td>59%</td>
<td>53.35% (Qtr 2)</td>
</tr>
<tr>
<td>Reduce C. Difficile infection rates</td>
<td>Number of cases of C.Difficile in both community and hospital settings</td>
<td>234</td>
<td>202</td>
<td>102 (August)</td>
</tr>
<tr>
<td>Increase percentage of drug users in effective treatment</td>
<td>Number of drug users remaining in effective treatment for 12 weeks or more</td>
<td>813</td>
<td>828</td>
<td>819 (Qtr 1)</td>
</tr>
</tbody>
</table>

Table 2 – WCC outcome measures
1.5 Our Values

We have developed, through extensive staff engagement, a set of values that we, in NHS Bedfordshire, will live by in our daily work. As the leader of the NHS in Bedfordshire, our values will underpin how we deliver this strategy across the local health system and will determine the behaviours we expect across the local NHS. These are:

Work together
I am proud to belong to an organisation that delivers exceptional service.

Respect for all
I contribute to a caring and supportive environment that values everyone.

Aim for excellence
I take responsibility and strive to achieve the best at all times.

Be open to change
I am open to change. I challenge when necessary.

Be positive
I play my part in making this a great place to work.

Be clear and simple
I always listen, respond and act openly and honestly.

2 Bedfordshire Today and in the Future

- The health of people in Bedfordshire is generally similar to or significantly better than the England average. Rates of breastfeeding initiation remain below the national average but have increased by over 9% in 12 months, bringing them in line with the East of England average.

- Life expectancy in Bedfordshire is slightly lower than the East of England average.

- There are health inequalities within Bedfordshire by location, gender, income and ethnicity. For example, the largest difference in life expectancy between medium sized geographical areas within Bedfordshire is 12.7 years.

- Over the past ten years, rates of death from all causes have decreased. Early deaths due to heart disease and stroke have remained better than or close to the England average. Deaths from cancer remain below the current national levels; they have not reduced at the same rate as the England average.

- Smoking kills around 520 people each year in the county.
• Teenage conception rate is lower than the England average, although rates have risen in Bedford.

• Overall the level of childhood obesity is similar to that of England, although this masks wide local variation. Almost one adult in four is obese.

• Bedfordshire is generally affluent with pockets of extreme deprivation.

• Bedfordshire has an increasing and ageing population.

The Joint Strategic Needs Assessment (JSNA) for Bedfordshire was published in January 2009 and is currently being updated to reflect the changes in local government. It will ensure we have an up to date picture of local health needs to inform the commissioning decisions in health and local government. It is being undertaken in partnership with the unitary authorities and other partners and will focus upon the needs at key periods in individuals’ lives: childhood, adult and older age.

2.1 Population

The current age and sex structure of Bedfordshire’s population is shown below. It is similar, but not identical, to that of the East of England. The structure is a result of varying birth and death rates in the past as well as net immigration, which happens more in certain age groups.

Births are predicted to remain relatively stable at approximately 5,000 a year across Bedfordshire over the next 12 years.
Proportions of people aged 0-15 or 65+ are similar across the districts, though Central Bedfordshire has a lower percentage of older people compared to Bedford Borough. Bedfordshire has proportionally fewer older people than the East of England and slightly more young people, as shown Table 1.

<table>
<thead>
<tr>
<th>Proportion</th>
<th>Bedfordshire</th>
<th>Bedford Borough</th>
<th>Central Bedfordshire</th>
<th>East of England‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>411,900</td>
<td>157,000</td>
<td>254,900</td>
<td>5,728,700</td>
</tr>
<tr>
<td>Aged 0-15</td>
<td>80,100</td>
<td>30,900</td>
<td>49,200</td>
<td>1,087,800</td>
</tr>
<tr>
<td></td>
<td>(19.4%)</td>
<td>(19.7%)</td>
<td>(19.3%)</td>
<td>(19.0%)</td>
</tr>
<tr>
<td>Aged 65+</td>
<td>63,200</td>
<td>25,000</td>
<td>38,300</td>
<td>970,400</td>
</tr>
<tr>
<td></td>
<td>(15.3%)</td>
<td>(15.9%)</td>
<td>(15.0%)</td>
<td>(16.9%)</td>
</tr>
</tbody>
</table>

Table 3 – Population summary (mid year 2009 forecast)


The changes in the age structure of the population for males and females over the next five years is shown in the following two tables.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4s</td>
<td>12731</td>
<td>12867</td>
<td>13015</td>
<td>12991</td>
<td>12992</td>
<td>12955</td>
<td>12908</td>
<td>12852</td>
</tr>
<tr>
<td>5 to 9s</td>
<td>12526</td>
<td>12497</td>
<td>12598</td>
<td>12846</td>
<td>12987</td>
<td>13139</td>
<td>13322</td>
<td>13541</td>
</tr>
<tr>
<td>10 to 14s</td>
<td>13225</td>
<td>13042</td>
<td>12904</td>
<td>12906</td>
<td>12633</td>
<td>12531</td>
<td>12537</td>
<td>12750</td>
</tr>
<tr>
<td>15 to 19s</td>
<td>13595</td>
<td>13328</td>
<td>13018</td>
<td>12652</td>
<td>12598</td>
<td>12577</td>
<td>12430</td>
<td>12247</td>
</tr>
<tr>
<td>20 to 24s</td>
<td>12071</td>
<td>12382</td>
<td>12505</td>
<td>12626</td>
<td>13108</td>
<td>12998</td>
<td>12809</td>
<td>12424</td>
</tr>
<tr>
<td>25 to 29s</td>
<td>11667</td>
<td>11672</td>
<td>11676</td>
<td>11681</td>
<td>11974</td>
<td>12267</td>
<td>12561</td>
<td>12854</td>
</tr>
<tr>
<td>30 to 34s</td>
<td>12973</td>
<td>12817</td>
<td>12662</td>
<td>12506</td>
<td>12625</td>
<td>12743</td>
<td>12861</td>
<td>12979</td>
</tr>
<tr>
<td>35 to 39s</td>
<td>15645</td>
<td>15221</td>
<td>14797</td>
<td>14372</td>
<td>14315</td>
<td>14257</td>
<td>14199</td>
<td>14142</td>
</tr>
<tr>
<td>40 to 44s</td>
<td>17095</td>
<td>17070</td>
<td>17044</td>
<td>17018</td>
<td>16668</td>
<td>16318</td>
<td>15967</td>
<td>15617</td>
</tr>
<tr>
<td>45 to 49s</td>
<td>15804</td>
<td>16199</td>
<td>16594</td>
<td>16988</td>
<td>17005</td>
<td>17022</td>
<td>17039</td>
<td>17056</td>
</tr>
<tr>
<td>50 to 54s</td>
<td>13405</td>
<td>13830</td>
<td>14255</td>
<td>14679</td>
<td>15098</td>
<td>15517</td>
<td>15935</td>
<td>16354</td>
</tr>
<tr>
<td>55 to 59s</td>
<td>12946</td>
<td>12684</td>
<td>12422</td>
<td>12160</td>
<td>12602</td>
<td>13044</td>
<td>13486</td>
<td>13928</td>
</tr>
<tr>
<td>60 to 64s</td>
<td>11447</td>
<td>11875</td>
<td>12303</td>
<td>12732</td>
<td>12507</td>
<td>12282</td>
<td>12058</td>
<td>11833</td>
</tr>
<tr>
<td>65 to 69s</td>
<td>8875</td>
<td>9176</td>
<td>9477</td>
<td>9778</td>
<td>10209</td>
<td>10639</td>
<td>11070</td>
<td>11501</td>
</tr>
<tr>
<td>70 to 74s</td>
<td>7000</td>
<td>7171</td>
<td>7341</td>
<td>7512</td>
<td>7816</td>
<td>8120</td>
<td>8424</td>
<td>8727</td>
</tr>
<tr>
<td>75 to 79s</td>
<td>5484</td>
<td>5578</td>
<td>5672</td>
<td>5766</td>
<td>5955</td>
<td>6144</td>
<td>6333</td>
<td>6522</td>
</tr>
<tr>
<td>80 to 84s</td>
<td>3664</td>
<td>3788</td>
<td>3913</td>
<td>4037</td>
<td>4162</td>
<td>4287</td>
<td>4411</td>
<td>4536</td>
</tr>
<tr>
<td>85 to 89s</td>
<td>1807</td>
<td>1927</td>
<td>2047</td>
<td>2167</td>
<td>2285</td>
<td>2403</td>
<td>2521</td>
<td>2639</td>
</tr>
<tr>
<td>90+</td>
<td>738</td>
<td>801</td>
<td>864</td>
<td>926</td>
<td>1025</td>
<td>1126</td>
<td>1227</td>
<td>1327</td>
</tr>
<tr>
<td>Total</td>
<td>202699</td>
<td>203924</td>
<td>205106</td>
<td>206344</td>
<td>208562</td>
<td>210369</td>
<td>212099</td>
<td>213830</td>
</tr>
</tbody>
</table>

Table 4 – Bedfordshire – male population estimates and projections 2008 to 2015
Table 5 – Bedfordshire – female population estimates and projections 2008 to 2015

Source: Bedfordshire County Council

Three of the years (2009, 2012 and 2015) given in the tables above are shown diagrammatically in the two charts below. (Note: similar data at district level is available).

Figure 3 – Predicted age structure, males 2009, 2012 and 2015
The life expectancy figures quoted make no allowance for forecast future changes in mortality. The latest from the Office of National Statistics as per the statement below suggests that the average life expectancy for a 65 year old man is to reach age 86 and for a woman to reach age 88.6. It is even longer (88.6 (men) and 92.2 (women)) for those born today who can enjoy the benefits of better preventive and curative health services. Even more reason to have a well prepared pension scheme.

2.2 Bedfordshire’s Ageing Population

The number of older people is increasing as a result of people living longer and the post-war ‘baby-boom’ generation age. The most dramatic percentage increases will be seen in those aged 85 and over. Between 2008 and 2013, the number of women in this age group is set to increase by 21% and the number of men will increase by 27% - more than 3,000 additional very old people in total.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2006-2011</th>
<th>2011-2016</th>
<th>2016-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school (&lt;5)</td>
<td>4.3%</td>
<td>-1.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>School age (5-15)</td>
<td>-2.7%</td>
<td>2.8%</td>
<td>3.0%</td>
</tr>
<tr>
<td>School leavers/FE (16-19)</td>
<td>-5.1%</td>
<td>-1.7%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Working age (20-64)</td>
<td>2.4%</td>
<td>2.1%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Post-retirement (65-74)</td>
<td>14.6%</td>
<td>21.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Older people (75+)</td>
<td>14.4%</td>
<td>16.0%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Very old people (85+)</td>
<td>27.1%</td>
<td>23.6%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Total population</td>
<td>3.2%</td>
<td>4.4%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

Table 6 – Predicted population changes in Bedfordshire

Source: Population Estimates and forecasts Bedfordshire County Council 2008 Tables 4.2 - 4.8 and Appendix A3
There are 61,700 people aged 65 and over living in Bedfordshire, which is predicted to rise to over 72,200 by 2013 and to 88,800 by 2021. The highest population of older people is in Bedford Borough, particularly in the rural wards of north east Bedfordshire. Population estimates suggest that mid Bedfordshire will experience the largest growth of older people over the next 10-20 years.

As Bedfordshire’s population ages, the number of people with poor health in Bedfordshire will rise.

- As a county, estimates have been made of the numbers of people aged 65 and over unable to manage at least one mobility activity on their own. Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house; getting to the toilet; and getting in and out of bed. The numbers for Bedfordshire are currently 9,300, rising to 11,400 by 2015.

- Around 20% of people aged over 75 are registered blind or partially sighted; this equates to 5,600 people in Bedfordshire in 2008 and 6,700 by 2015.

- The number of obese people aged 65 and over with a body mass index (BMI) above 30 is estimated to be 14,800 in 2008, rising to 18,300 by 2015. Increasing obesity will drive rising levels of diabetes and associated complications.

- The prevalence of incontinence for people living at home is between 7-10% for men aged 65 and over and 10-20% for women aged 65 and over. For Bedfordshire this amounts to between 5,200 and 9,400 people aged 65 and over with an incontinence problem who live in the community in 2008, rising to between 6,500 and 11,600 by 2015.

- It is estimated that there are 4,230 people aged 65 and over who have a long standing health condition caused by a heart attack and that this will rise to 5,285 by 2015.

- It is estimated that there are 1,340 people aged 65 and over who have a long standing health condition caused by bronchitis and emphysema and that this will rise to 1,690 by 2015.

- The number of people aged 65 and over who attend hospital A&E departments as a result of falls in Bedfordshire is predicted to rise from 3,700 in 2008 to 4,500 by 2015. Hospital admissions resulting from falls in the same age group is predicted to rise from 1,300 in 2008 to 1,500 by 2015.

- As a result of the ageing population, we expect substantial growth in the prevalence of dementia, which could rise by as much as 20% by 2016. The increases in other mental health problems are expected broadly to follow the overall population change, mostly in the range of 4-8% increases.

2.3 Ethnicity

People from black and minority ethnic groups represent 11% of the county’s total population and are mainly concentrated in the urban area of Bedford.
People from some ethnic groups have a much younger age profile, particularly the Pakistani, Bangladeshi, and mixed White and Black Caribbean communities. These groups tend too have a higher fertility rate than average and can be expected to form a larger percentage of the population in future years.

### 2.4 Deprivation and Current Health Inequalities

Deprivation is measured by the Department for Communities and Local Government and a score, the Index of Multiple Deprivation (IMD), is produced for small geographic areas in England. By arranging these in rank order and then dividing them into five equal groups or quintiles, the relative levels of deprivation in a larger area can be visualised. These quintiles are numbered 1 (least deprived) 2, 3, 4 and 5 (most deprived).

Across the whole of England, there are an equal number of areas in each of the five quintiles. Figure 7 shows how many of areas within Central Bedfordshire and Bedford Borough belong to each quintile.

The IMD includes elements relating to poverty and poor housing. Higher levels of deprivation in a local authority correlate to reduced life expectancy when considered across the whole of England, but do not account for all the differences seen in life expectancy. For small areas within Bedfordshire the correlation is weak. However, the IMD is still useful in identifying small areas where poverty may affect health.
Figure 5 – Residents living in five deprivation bands
Figure 6 - IMD 2007 score at LSOA level
Life expectancy is a useful overall measure of health. Recently, measures of life expectancy have become available at medium sized geographic areas (Middle Super Output Area – MSOA). These help us identify areas with lower life expectancy, whether they are deprived or not. At MSOA level the maximum life expectancy was 84.5 years and minimum was 73.9 years, a difference of 10.6 years.

Figure 7 - Life expectancy at MSOA level
2.5 Comparison of Key Health Indicators

The indicators below show how Bedfordshire compares with the rest of the East of England and with England as a whole.

![Figure 8 - Key health indicators](image)

- Cardiovascular disease and diabetes disproportionately affect those in areas of high deprivation.
- Educational achievement is one of the predictors of life expectancy and is lower in areas of higher deprivation.
- There are important inequalities in health between different geographical areas and marginalised groups.

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Deprivation</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.2</td>
<td></td>
<td>0.0</td>
</tr>
</tbody>
</table>

% of people in this area living in 20% most deprived areas of England 2005

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Obese Children</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1</td>
<td></td>
<td>4.9</td>
</tr>
</tbody>
</table>

% of schoolchildren in reception year

- In 2007/08, 8.7% of 4-5 year olds and 15.1% of 10-11 year olds across Bedfordshire were obese. An additional 12.5% of 4-5 year olds and 13.1% of 10-11 year olds were overweight.
- Children who are obese are more likely to grow up to be obese adults and present a range of co-morbidities at an earlier age than if they where not obese.
- Obese children are more likely to suffer psychological abuse at school and in the community.

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Adults Who Smoke</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.9</td>
<td></td>
<td>13.7</td>
</tr>
</tbody>
</table>

%, direct estimate from health survey for England
• Smoking is the biggest single cause of preventable illness, inequalities in health and early death in the UK.

• Smoking kills more than 120,000 people in the UK each year and costs the NHS up to £1.7 billion a year in England.

• Current estimates are that 84,000 adults in Bedfordshire smoke and we are achieving reductions in prevalence.

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Drug Misuse</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.9</td>
<td>Crude rate per 1000 population aged 15-64</td>
<td>1.3</td>
</tr>
</tbody>
</table>

• Drug misuse is an issue that has an impact on our local community in a number of different ways, having social, financial and health related implications.

• In 2007/08 the number of problematic drug users in Bedfordshire was 1,946.

• A number of initiatives are in place locally to support individuals who misuse substances. In 2007/08 the number of problematic drug users in Bedfordshire who were engaged in an effective treatment programme was 788.

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Breast Feeding Initiation</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.2</td>
<td>% of mothers initiating breast feeding where status known 2006-2007</td>
<td>90.9</td>
</tr>
</tbody>
</table>

• Breastfeeding is accepted as the best form of nutrition for infants to provide all of the vital nutrients, as well as health benefits for both mother and child.

• Exclusive breastfeeding is recommended for the first six months of an infant’s life.

Breastfeeding initiation rates in Bedfordshire are continuing to rise. In 2006/07 the breastfeeding initiation rate in Bedfordshire was 58.5%, rising to 62.2% in 2007/08 and to 71.5 % in 2008/09.

<table>
<thead>
<tr>
<th>England Worst</th>
<th>Statutory Homelessness</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.4</td>
<td>Crude rate per 1,000 households 2005-2006</td>
<td>0.0</td>
</tr>
</tbody>
</table>

• The number of households officially recognised as newly homeless in Bedfordshire in 2007 was 688. National league tables (CLG 2008) shows Bedford ranked as 70th highest in England (363 homeless), whilst south Bedfordshire was 145th (180 homeless) and mid Bedfordshire 203rd (145 homeless).

• 70 -80% of households placed in temporary accommodation are likely to have complex and interrelated support needs which requires joined up working at strategic and operational level.
On average, both men and women in Bedfordshire live longer than men and women in England. Life expectancy is increasing more rapidly in men, reducing the gap between female and male life expectancy.

The Foresight Report (2007) identifies that levels of obesity will reach almost 60% by 2050, if unchecked.

Unmanaged obesity can lead to a range of chronic conditions including type II diabetes, CHD, stroke, hypertension, several cancers, up to nine years lost life and a range of psychosocial issues.

It is estimated that one fifth of the adult population in Bedfordshire are currently obese and 40% of men and 30% of women are overweight.

The direct healthcare costs of managing overweight and obesity are predicted to rise by 700% by 2050.

The second most common cause of death in Bedfordshire is cardiovascular disease.

The most common cause of death is all cancers. However, death from CVD is higher in the Bedford area and is more closely linked to deprivation than cancers.
England Worst People Diagnosed With Diabetes

<table>
<thead>
<tr>
<th>England Worst</th>
<th>People Diagnosed With Diabetes</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.9</td>
<td></td>
<td>2.1</td>
</tr>
</tbody>
</table>

% people on GP register with a recorded diagnosis of diabetes

- Diabetes type II is increasing due to an ageing population and rising levels of obesity.
- The number of people with diabetes on GP registers has increased from 13,500 in March 2005 to 15,950 in March 2008.
- Poor achievement at GCSE level is a risk factor for poorer health in later life so improving educational levels for today’s students will bring future health benefits.

England Worst GCSE Achievement (5 A* - C)

<table>
<thead>
<tr>
<th>England Worst</th>
<th>GCSE Achievement (5 A* - C)</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.5</td>
<td></td>
<td>82.7</td>
</tr>
</tbody>
</table>

% at key stage four

- The 5A* to C including English and Mathematics improved by 1.8%. This continues the upward trend from 2005.
- Two schools have now broken the 80% with a further four schools above 70%. Overall there has been an improvement of 4.7% lifting the result to 62.8% from 58.1% in 2007.
- Results in English and Mathematics continue to show progress, with increases of 2.5% and 3% respectively.
- Where there has been a significant level of intervention by the local authority, results have advanced by 13% on average. The universal programmes for Maths and English have led to improvements of around 3% with some more substantial gains for individual needs.

2.6 Future Health Inequalities

Predicting inequalities across small areas is complex. Over the period 2002 to 2005, the gap between average premature death rates in Bedfordshire’s least and most deprived fifth of MSOAs increased. By contrast, the gap in all-age, all-cause mortality between these groups has decreased slightly. Due to the small numbers involved, additional years of information is needed to understand the true trend, although currently there is no robust local evidence that health inequalities are decreasing.

Nationally life expectancy at birth is increasing for both men and women, including in the most deprived areas (fifth quintile), but it is increasing more slowly in these deprived areas, so the gap continues to widen and it is widening more for women than men.

In the period 2004-2006, for males the relative gap was two per cent wider than at the baseline (the same as in 2003-2005), for females 11% wider (compared to eight per

2.7 Impact of Increasing Technology

Medical advances can improve health outcomes, but will create budgetary pressures. Significant advances in medicine and surgery are anticipated, supported by the increasing insight offered by genetics. The “capacity to treat” is increasing, especially for the older frail. This magnifies the potential demand of an ageing population. Advances in information technologies enable improved models of care. The capacity to share clinical information and expertise between professionals and patients offers many opportunities for patients to take a positive and active role in their care and improve the quality of patient care and outcomes.

Horizon scanning of the clinical, technology and policy landscapes is a work stream within NHS Bedfordshire’s strategic programme to develop a world class organisation.

2.8 Rising Expectations and the Challenges we Face

The expectations of society are changing. Rising education and income levels are helping to drive higher public expectations of health and health care services. In the future, older people are expected to demand much more from health and social care services than older people do today.

Bedfordshire is an area targeted for new housing developments. The East of England Plan > 2031 (Scenarios for Housing and Economic Growth)\(^1\) predicts 19,400 to 22,000 new dwellings between 2011 and 2031. The resulting increase in population (46,560 to 48,744 based on ONS average of 2.4 persons per dwelling) is unlikely to be matched immediately by a corresponding increase in central funding for their health needs.
As our population ages, more people will suffer from long term conditions and will require support to maintain healthy, independent lives.

- Advances in technology will enable us to do more for patients, but this will increase the pressure on our allocated budget.
- In a consumer-driven society, people will continue to expect more from their NHS.
- In many cases, growth is also planned to occur outside of the localities areas currently served by health facilities, presenting a challenge to ensure access to services is equitable.

**Milton Keynes South Midlands Growth Area**

In order to successfully predict and plan services across the Milton Keynes South Midland (MKSM) growth area, NHS and social care commissioners are working in partnership to develop a service strategy for implementation. Partners include:

- NHS Bedfordshire
- NHS Buckinghamshire
- NHS Milton Keynes
- NHS Luton
- NHS Northamptonshire
- All partner local authorities

A Milton Keynes South Midlands Health and Social Care Group (HSG) has been established and is responsible for ensuring that all agencies commission health and social care services to meet the needs of the MKSM population group area. Key priorities are currently being reviewed, but an immediate priority is undertaking capacity modelling to inform service reconfiguration.

**Capacity Modelling Across MKSM**

NHS Northamptonshire is hosting the MKSM Programme, which includes commissioning project support (Simul8) for the development of a capacity plan for each PCT, showing the impact of projected growth within their area on population, health care need and demand.

These plans will be developed in a consistent way to allow the development of an MKSM wide model and will be available to support the development of the 2010/11 planning cycle, starting in the autumn 2009.

Following this initial work, more detailed analysis and planning will be undertaken collectively on 10 key areas, agreed by partners, alongside the local planning by and strategy implementation by local leaders of NHS communities. The 10 key areas will support agreed priorities of the MKSM HSCG and its key areas of action.
Bedfordshire’s population is increasing as people live longer and new people move into housing developments. Bedfordshire is part of the Milton Keynes South Midlands growth area and significant development is planned around Bedford and the south of the county (see maps below). As one of the Government’s growth areas, the number of new houses built each year needs to increase by approximately 1,000 in order to meet the projected growth plans. It is estimated this will increase the amount of ‘built on’ land in Bedfordshire from 7.8% in 2005 to 12.2% by 2013.

The population model, unlike the ONS population model, takes into account the planned housing developments as well as the ageing population in the projections given in the tables and charts that follow. Due to the recent economic downturn, there has been a pause in house building in Bedfordshire and this is reflected in the revised population model.

The total population is set to increase over the next six years by 5.7% from 411,900 in 2009 to 435,300 by 2016.
Figure 10 - Bedford and Marston Vale growth areas (Renaissance Bedford)

Figure 11 – Potential areas for development: Luton and South Bedfordshire
3 Insights of Patients, Public, Clinicians and Partners

We have undertaken significant consultation with our stakeholders to get to where we are. Their views have contributed to the development of this strategy and its eight implementation plans across the life pathway from birth to end of life.

3.1 Developing Our Strategy

In 2007, we published our early thinking on a medium term health strategy for Bedfordshire in a document that set out our strategic intentions in respect of:

- Improving health, preventing illness.
- Developing services for the future.
- Strengthening primary care.
- Supporting and enhancing local services.
- Developing mental health services.
- Services for children and young people.
- Modernising acute hospital services.
- Cancer services and palliative care.
- Workforce planning.
- Funding.

We presented this to the Bedfordshire and Luton Joint Health Overview and Scrutiny Committee (OSC) in February 2007. The OSC welcomed the strategy as a key element in framing the delivery of NHS services in Bedfordshire over the next five years. It made a number of recommendations in its response: the need to establish an underpinning vision; greater emphasis on desired outcomes, actions and SMART targets; more detailed financial context; inclusion of a substantial risk analysis; and more consideration of the impact of population growth and demographic change.

The full document and a 12 page summary were published on the NHS Bedfordshire website and sent to a range of stakeholders in March 2007, including:

- All 240 members of our Health Panel.
- Our PPI Forum.
- Older people’s groups.
- Patient, service user and carer groups.
- Third sector organisations.
- Health and Social Care statutory and professional bodies.
- Local government (County, Borough, District and Parish Councils).

In general, people welcomed the ambition and breadth of the draft strategy. They strongly supported partnership working, with more integration of health and social care over time. Some expressed concern about whether there would be sufficient
funding to fully implement it. Others wanted to see more details on the impact of
demographic change. Many welcomed the opportunity to offer their views and our
commitment to ensure ongoing engagement as we develop and implement our plans.
These and specific comments on each of the key sections has informed the further
development of this strategy.

Our strategy is also informed by the national review of the NHS by Lord Darzi, by the
ten year vision for the NHS in the East of England, Towards the best, together and by
the eleven pledges, set out in Improving Lives, Saving Lives, to improve the NHS in
this region over the next three years.

Alongside this work to draw out and clarify our strategic goals and the strategic
priorities that underpin their delivery, we have engaged with and involved many
different people as patients, residents, clinicians and strategic partners to shape and
test out our implementation plans for the eight clinical plans.

We held a 12 week public consultation on our strategy from 16 March to 8 June 2009.
Through a consultation questionnaire, online responses and a series of consultation
workshops across the county, we gathered the views comments and suggestions of
454 people drawn from the public, patients and a broad range of other stakeholders.

There was strong support for each of our three strategic priorities. Responses from
consultees voiced benefits that included:

- Prevention is a more cost effective use of resources
- Prevention improves the quality of life and reduces the long term effects of
  illness
- Prevention is empowering and prevents co-morbidities
- Targeting deprived areas is socially responsible and more cost effective
- More local services are more convenient, comfortable, less stressful and more
  accessible
- Local services are more personal and promote greater continuity of care
- Moving some services into the community allows hospitals to focus on more
  critical services
- More choice may provide competition, which may drive up quality and improve
  the patient experience.

Some concerns and areas for further consideration were also voiced, such as:

- Prevention is a long term endeavour and this needed to be balanced with
  shorter term treatment needs
- Deprivation cannot be reversed by the NHS
- Community based services will not always be the best solution
- Moving services from hospital to community may adversely affect hospitals
- Wider choice may be confusing for some patients
- Extending choice may cost more.

The former Bedfordshire County Council Health and Adult Social Care Overview and
Scrutiny Committee (OSC) established a member task group that met three times to
scrutinise our strategy. With the establishment of the two unitary authorities in April 2009, a statutory joint OSC was established to continue the scrutiny process and produce a report. This contained 62 detailed recommendations. The strategy was broadly welcomed in its aims and ambitions. The key themes emerging from their report can be summarised as:

**Partnership working**: the strategy must be embedded with the local authorities within joint strategic planning and partnership working.

*Our response*: Partnership working is accepted as integral to all delivery plans. As demonstrated by the recent establishment of joint strategic planning arrangements in the two new unitary authorities: Central Bedfordshire Healthier Communities and Older People Partnership Board; Bedford Borough Health and Wellbeing Partnership Board; and ‘Be Healthy’ groups for Bedford Borough and Central Bedfordshire. Both Partnership Boards are co-chaired by the Director of Adult Social Care and the Director of Health System Management; sub-groups will be chaired by either a local authority or NHS Bedfordshire service manager.

**Deliverability**: the strategy must be financially viable and deliverable within the constraints of the current financial climate.

*Our response*: NHS Bedfordshire is further developing its financial modelling and scenario planning and capability as part of its World Class Commissioning Development Plan. NHS Bedfordshire recognises this as a key priority and will continue to focus on robust financial planning that ensures delivery of the strategy whilst also delivering value for money within the available resources. NHS Bedfordshire is working on a number of future financial scenarios and the strategy will be refreshed accordingly. The three strategic priorities will, however, remain at the heart of the strategy.

**Evidence based**: the strategy must be underpinned by robust evidence and data that inform commissioning and prioritisation decisions.

*Our response*: The pledges and World Class Commissioning (WCC) health outcome measures will continue to be monitored as the measures of our success. Work has started on the development of locality based profiles with each of the Practice Based Commissioning (PBC) groups and practices across Bedfordshire. These profiles will contain a range of information from the Joint Strategic Needs Assessment (JSNA) and other sources to provide a detailed understanding of demography, epidemiology service activity and spend. This will inform strategic planning and prioritisation and ensure that commissioning decisions are based upon local requirements. The impact and outcome of these interventions will be monitored closely to ensure that improved health outcomes are achieved. Research evidence supporting the direction set out in the strategic priorities will be shared widely.

**Outcome directed**: SMART targets are required to ensure that the progress and success of the strategy can be monitored and achieved.
Our response: NHS Bedfordshire will continue to develop and use a set of SMART targets and action plans linked to the delivery of the strategy. These will be clearly linked to the 11 World Class Commissioning Health Outcomes.

The responses received from the consultation have given us a valuable insight into a range of issues that have informed this refreshed strategy document.

The full consultation report and the report of the joint OSC are available on our website www.bedfordshire.nhs.uk

3.2 Patient and Public Engagement

Alongside this work to draw out and clarify our strategic goals and the strategic priorities that underpin their delivery, we have engaged with and involved many different people as patients, residents, clinicians and strategic partners to shape and test out our implementation plans for the eight clinical plans.

3.2.1 Staying Healthy

We have met with vulnerable and marginalised groups in a range of settings to talk to them about their health needs. This included:

- Meeting homeless people in day and night shelters.
- Going to traveller sites to talk to residents.
- Speaking to prisoners at Bedford Prison and to offenders in the community.
- Commissioning a voluntary organisation to find out about the health needs of looked after and vulnerable children and young people across Bedfordshire.
- We consulted widely on our obesity strategy, seeking views from voluntary, public and private sectors.
- Health and well being priorities for the Local Area Agreement were consulted on at two Countywide Assemblies, each attended by 150-200 stakeholders.
- Horizon Health Commissioning, the practice based commissioning group for Bedford, ran a workshop in December 2007 with health, social care, patient/service user and community representatives to inform the development of commissioning plans for obesity, diabetes and coronary heart disease. An inequalities questionnaire was sent to 125 Health Panel members and other stakeholders, which informed a second workshop on health inequalities in September.
- We participated in a series of events in April 2008 organised by Bedford Borough Council to seek the views of residents in two rural and two urban Super Output Areas.
- Patient and public engagement and consultation has been integral to informing the Bedfordshire sexual health strategy and the vision for sustained development and improvement.
What People Have Told Us

- The GP leisure referral scheme was seen as very useful in treating unfit people. We need to find creative ways to promote and encourage more walking, cycling and other everyday activities.
- People generally thought there should be a strong focus on initiatives aimed at improving the health of children and young people. We should consult and involve young people in developing physical activity and healthy eating initiatives and interventions.
- Smokers who have attended stop smoking classes said they benefited from having dedicated, specialist support rather than more general, lower level advice.
- People want to see more workplace support for health initiatives, such as stopping smoking and exercise activities.
- The majority of people thought it right to target resources at where there were greatest health inequalities.
- Young people want sexual health services provided at convenient times, including weekends, in community settings where they feel comfortable and not stigmatised.

3.2.2 Mental Health

- NHS Bedfordshire and the unitary authorities have carried out a range of consultation events and activities during the development of our strategic plan for people with mental health problems.
- We value the views and contributions of our service users and carers through the Bedfordshire Mental Health Partnership Board.
- Service users and carers provide organised ‘expert’ advice and consultation during commissioning and are now an integral part of monitoring service performance management arrangements.

What People Have Told Us

- People would prefer to have their mental health managed in primary care. They saw admission to inpatient units as not the most therapeutic and wanted contact with specialist mental health services only as a last resort.
- There was a strong sense of the need for robust crisis response services, particularly out of hours, with alternatives to admission being a high priority for many.
- Many people felt that housing and supported accommodation were a particular need.
- Service users should be given greater choice.
- Services should be improved for black and ethnic communities.
- Improvements should be made to mental health promotion.
3.2.3 Maternity and New Born

- The Audit Commission patient survey of maternity services at Bedford Hospital has informed the establishment of some priority areas for development as part of NHS Bedfordshire’s maternity strategy.
- We engaged with service users as part of our review of maternity services in 2007. We are continuing to seek their views, through stakeholder groups and other activities, in developing our maternity strategy.
- There is an active Maternity Services Liaison Committee (MSLC) for Bedford Hospital, chaired by a service user and with clinical and service user representation. We are developing a recruitment pack and associated promotional activities to further strengthen user representation.
- Regular commissioning meetings with maternity teams at Luton and Dunstable Hospital and Bedford Hospital ensure ongoing clinical engagement.

What People Have Told Us

- With mothers now more likely to be discharged earlier, women wanted more postnatal support, particularly in the early period.
- Provide better education and support, in general, to promote and increase breastfeeding.
- Women wanted more support to make healthy lifestyle choices during pregnancy, for example in diet and help to stop smoking.
- Provide targeted support for vulnerable mothers, for example among teenage mothers.
- Offer better perinatal mental health support.

3.2.4 Children’s Services

- Multi-agency strategy groups for a range of clinical areas provide input into strategy development from clinicians, local authority and voluntary sector representatives.
- The annual national Tellus surveys and the local Balding survey provide views from children and young people on health services in Bedfordshire, which informs service planning and commissioning.
- During 2009 we consulted with CAMHS users and children and young people in school settings about their needs and services provided to address their emotional health and wellbeing.
- Consulted with young people on their views on short breaks for children with disabilities.
- Parents are involved in the implementation of priorities for paediatric and services for children with complex needs.
• Bedford Borough Council and Central Bedfordshire Council employ children’s participation officers to promote engagement and gather views.

• Parents have been involved in a recent review of paediatric therapies through the local authorities’ parent partnership initiative. This provides opportunities for planned and sustained public involvement in the development of children’s services.

What People Have Told Us

• Early support and clear, reliable information is important to help children (and their parents) make healthy lifestyle choices.

• Children and young people wanted more children’s services provided in community settings, closer to home and in familiar places. They wanted more services grouped together as ‘one-stop shops’ that were open at weekends.

• The importance of good people skills was stressed. Staff needed special training and skills to build relationships with young people. Young people tended to feel that this to be more important than technical / clinical skills.

3.2.5 Planned Care

• We consulted patients of Putnoe Medical Centre as part of the process to develop a new GP-led health centre. Their views informed the service specification and the selection panel included patient and other lay representation.

• We consulted patients of the seven GP practices in Dunstable on GP-led proposals to build a new medical centre. Around 300 people attended public meetings and we received more than 4,700 responses by freepost, email and website.

• We are consulting 15,000 patients from October to January on GP-led proposals to build a new health centre in Shefford.

• NHS Bedfordshire, in collaboration with Bedford Hospital and Horizon Health Commissioning, was selected as one of 10 pilots nationally to develop ideas to improve communications with patients on 18 weeks. We are producing a patient held folder, developed with patient input, which we will be piloting and evaluating with up to 300 patients at four GP practices.

What People Have Told Us

• Local consultations revealed that people welcomed more care delivered in community setting, closer to home. This included some less complex care more traditionally provided in hospitals and more diagnostic services. They tended to support proposals to build modern, larger health facilities to accommodate this, but these needed to be in convenient locations or have good public transport for easy access, particularly for older people, people with a disability and mothers with young children.

• People supported the separation of planned and emergency care and that hospitals should also concentrate on more complex, specialised care.
• Patients, particularly those who commuted, wanted longer opening times in the evening and at weekends in primary care.

• People wanted more flexible appointment systems in GP practices.

• Patients welcomed more choice about where and when they are treated, but were not always aware of what was available.

• People wanted the choice to be treated by an NHS dentist. It has been clear that people have not been fully aware of the availability of NHS dental care within reasonable distances of their home.

• People welcomed shorter waiting times from referral to the start of their treatment, but wanted reassurance that this would not compromise the quality of the care they received.

3.2.6 Acute Care

• We have established an Acute Care Project Board as a strategic planning group for Bedfordshire with key stakeholders including PBC’s and a lay representative. Patients are involved at the work stream level of service review including the single point of contact service, 1Call, which we launched last year. This will become part of the memorable number pilot which will be developing in 2010. This is a three digit number across East of England pilot site.

• We will be putting greater emphasis on patient feedback in A&E in our contract with Bedford Hospital, which is monitored by the Quality Schedule.

• NHS Bedfordshire commissioning managers meet patients in A&E on a quarterly basis at Bedford Hospital to gain a deeper insight into patient experiences of acute care and put forward recommendations.

• The 2008 Healthcare Commission report on urgent and emergency services rated Bedfordshire as ‘best performing’, giving us assurance that these services are meeting local needs. We continue to ensure effective service delivery to monitor services.

• Bedford Hospital is participating in the Releasing Time to Care, Productive Series and has also developed ‘lean’ methodology to improve efficiency and improve the patient pathway.

What People Have Told Us

• Patients had varying experiences of out of hours (OOH) GP services and wanted more consistency in provision.

• A patient survey of an in-hours GP urgent care pilot at Luton and Dunstable Hospital revealed that the service was well received. Such arrangements need to be well communicated to staff and patients.

• People do not want to stay in hospital any longer than they need, but want to know there is the necessary support in the community. They want to see more joined up services.
• A single point of contact for assessment and access to urgent care support was welcomed by referrers and patients.

• Patients expressed some concerns that highly specialised centres might be further away, although they tended to accept that greater specialisation could make services more effective and safer, leading to better health outcomes.

3.2.7 Long Term Conditions

• We have set up a Long Term Conditions (LTC) steering group to oversee the delivery of our strategy. Membership includes representatives from the two local authorities, carers, patients, secondary care, providers, third sector and PBC groups. Work streams have been set up to ensure that work is undertaken around the pathways related to LTC. These work streams have involvement from all members of the local health community and service users.

• This year we are focusing on the following conditions: Diabetes, Stroke Rehabilitation, COPD and Parkinson’s. We will ensure that we engage with people with these conditions

What People Have Told Us

• In general, people supported early intervention with those at a high risk of developing a long term condition later in life. It was important to strike the right balance between prevention and treating those who were living with long term conditions.

• People welcomed more screening and other diagnostic activities that would identify and support people at an early stage of their long term condition.

• People with long term conditions often have a range of health and social care needs across different disciplines. They told us that they wanted to see a much stronger emphasis on better integration of services, particularly in areas such as psychological support, rehabilitation, medicines management and palliative care.

• There was very strong support for the Expert Patient Programme and many also wanted to see a short refresher course offered.

• There were mixed views on patient held budgets. Some saw it offering greater choice and flexibility. Others were concerned that it would overload them, particularly as they felt they would most need to make use of it at a time when their health was poor.

• People with long term conditions supported having an individual health plan to help them better manage health crises. When they needed urgent or emergency care, they wanted rapid support. They strongly supported the idea of a single contact number.
3.2.8 End of Life Care

There have been a number of initiatives to support patient and carer involvement in palliative and end of life care across Bedfordshire. These include:

- Carers’ focus group to explore the patient and carer experience of all palliative and end of life care services across mid Bedfordshire.
- Cancer focus groups which are a critical part of the service improvement cycle.
- Patient Partnership Group at St Johns, Sue Ryder Hospice in Moggerhanger.
- A strategy to build on this work has recently been written in collaboration with the local cancer networks and Macmillan Cancer Support. This links with NICE Improving Outcomes Guidance (2004) and the Department of Health End of Life Care Strategy (2008).

What People Have Told Us

- Patients and their families want a seamless transition across hospital, hospice and community. This would be helped by a greater emphasis on good communication with patients and their families.
- It is well documented generally and borne out by our focus groups that people want more control over where they die. Most do not want to die in hospital.
- There needs to be greater consideration and assessment of the needs of carers and families, providing practical and emotional support throughout end of life care and during bereavement.

3.3 The NHS Constitution

Our strategy is also informed by and reflects the rights and pledges of the NHS to its patients.

The NHS Constitution states:

The NHS commits to inform you about the healthcare services available to you, locally and nationally.

The NHS commits to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.

The NHS commits to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services.

In addition to the duty of PCTs to involve their local populations in decisions about the planning and delivery of NHS services in their area, there are a number of policy commitments. Providing accurate and relevant information to support public
involvement is an essential element of this. Measures to support PCTs in achieving this include:

- Patients have the right to privacy and confidentiality and to expect the NHS to keep their confidential information safe and secure.

- Patients have the right of access to their own health records. These will always be used to manage your treatment in their best interests.

- Our NHS, our future: Leading local change (published in May 2008), which established clear processes for PCTs to involve patients and the public in decisions about changes to local services.

The World Class Commissioning programme is a challenging development programme for all PCTs. PCT capability is measured against ten competencies, including one on engaging with patients and the public. This includes a requirement for PCTs to ensure “that patients and the public understand how their views will be used, which decisions they will be involved in, when decisions will be made, and how they can influence the process, and publicise[s] the ways in which public input has influenced decisions”. The performance of all PCTs against these competencies will be measured for the first time in 2008/09.

The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions.

Providing effectively integrated care, achieving better outcomes for service users in a cost effective way, is a key priority for the NHS. In particular, improving integration between health and social care is an important ambition, as signalled in the White Paper Our health, our care, our say and in Putting People First, the recent cross-government agreement on adult social care.

Delivery of integrated care is currently a joint responsibility of the NHS and partner organisations, such as the social services departments including local authorities. The NHS has a duty to work in partnership with local authorities to provide you with effective, integrated and personalised services to meet your health and well-being needs. The delivery of services to improve the health and well-being of the local population is agreed by the NHS and its local authority partners in a Joint Strategic Needs Assessment.

The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.

This pledge goes beyond the specific legal requirements for NHS bodies. For example, in committing to ensure that its facilities are fit for purpose, the NHS recognises that the quality and design of buildings and their upkeep have a material impact on the health and well-being of those using them – both public and staff. Specific legal requirements are set out in health and safety legislation and the law relating to negligence. Requirements are also made clear in the duty to provide and maintain a clean and appropriate environment for healthcare, as set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infections. All
acute trusts are inspected against this code of practice by the regulator, currently the Healthcare Commission and, from April 2009, the Care Quality Commission. This pledge focuses on those things that the NHS commits to do alongside or in addition to its legal requirements. In particular:

NHS organisations should take account of the series of specifications and guidance that describe how to provide a clean and safe environment for patient care. For example, the National Specifications for Cleanliness in the NHS set out the standard of cleanliness expected, as well as suggesting the frequency of cleaning needed across the NHS. National best-practice guidance for the design and operation of healthcare facilities ensures that the NHS has the information it needs when refurbishing or rebuilding its facilities to meet both clinical requirements and patients’ expectations that their privacy and dignity will be respected and their comfort assured.

The NHS commits to work in partnership with you, your family, carers and representatives.

Working in partnership with individual patients is at the heart of many Department of Health policies. These are outlined in the White Paper Our health, our care, our say, which sets out how people can take greater control over their care. For example, through the ‘choose and book’ initiative, patients work in partnership with clinicians to arrange their care and book hospital appointments. The NHS is developing information prescriptions for people with long-term conditions to help clinicians signpost people to the right information at the right time.

Providing good quality, timely and relevant information is crucial, as are self care and self management support. Our Health, our care, our say sets out the NHS’s commitment to offer a care plan to everyone with a long-term condition by 2010. This is reiterated in the End of Life Care Strategy (2008) which sets out the need for every person at the end of life, and their carer, to be given a care plan to help ensure services are provided to meet their needs and preferences.

### 3.4 Patient Surveys

Understanding what people currently think about the healthcare services they receive is crucial to their continuous quality improvement. Patient surveys of local health services in primary care have been carried for the Healthcare Commission in 2004, 2005 and 2008, providing a critical insight into the experiences of the patients and identify areas of healthcare that should be improved upon. The trust has developed action plans to address the key issues raised.

The information presented in the Healthcare Commission benchmark reports has been converted from responses to questions into scores. It is possible to discern trends in patient experience by comparing the raw data for similar questions rather than the constructed scores.

The following information has been taken from the results of the patient surveys for Bedfordshire in 2005, 2006 and 2008. Overall, the following changes can be identified (best, middle and worst):
### Table 8 – Patient survey results 2004-2008

<table>
<thead>
<tr>
<th></th>
<th>%age 2004</th>
<th>%age 2005</th>
<th>%age 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who said they waited because they wanted to see a doctor of their choice.</td>
<td>41</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Patients who said they were seen as soon as they thought necessary.</td>
<td>60</td>
<td>83</td>
<td>82</td>
</tr>
<tr>
<td>Patients who said they should have been seen a lot sooner.</td>
<td>9</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Patients who said they were involved as much as they wanted to be about their care.</td>
<td>65</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td>Patients who said they got no information on side effects, but wanted some.</td>
<td>20</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Patients on a list with an NHS dentist.</td>
<td>55</td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>Patients not on an NHS dentist’s list who would like to be.</td>
<td>68</td>
<td>73</td>
<td>79</td>
</tr>
</tbody>
</table>

Most indicators showed improving patient experience from 2004 to 2005 and from 2004 to 2008, but with some deterioration between 2005 and 2008. We will continue to analyse this year on year.

NHS Bedfordshire will establish arrangements through the contracting team for capturing patient feedback within two weeks of care. This is one of the CQUIN indicators. We will participate in quarterly national and regional surveys, as required.

Patient experience is an integral part of the existing performance reporting arrangements against the pledges to the PCT Board. Regular reports on patient experience will be provided. We also consider other patient experience survey reports, including the Care Quality Commission inpatient survey and the Annual Health Check of provider trusts. The most recent results are set out below.

### 3.5 Bedford Hospital 2008/09

<table>
<thead>
<tr>
<th>Quality of services</th>
<th>Quality of financial management</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Quality of services" /></td>
<td><img src="image" alt="Quality of financial management" /></td>
</tr>
<tr>
<td>This score covers a range of areas including safety of patients, cleanliness and waiting times.</td>
<td>This score looks at how well the organisation manages its finances.</td>
</tr>
<tr>
<td>More on quality of services</td>
<td>More on quality of financial management</td>
</tr>
<tr>
<td>2006/2007 FAIR</td>
<td>2006/2007 FAIR</td>
</tr>
</tbody>
</table>

Table 9 – Bedford Hospital Health Check rating
## What Patients Say

<table>
<thead>
<tr>
<th>Questions about…</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The emergency / A&amp;E department, answered by emergency patients only</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting lists and planned admissions, answered by those referred to hospital</td>
<td>5.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting to get to a bed on a ward</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td>The hospital and ward</td>
<td>7.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Doctors</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Nurses</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Operations and procedures, answered by patients who had an operation or procedure</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>6.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>6.1</td>
<td></td>
</tr>
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</table>

Table 11 – Bedford Hospital summary patient survey scores 2009
3.6 Bedfordshire and Luton Community NHS Trust 2008/09

Table 12 – Bedford and Luton Community NHS Trust Health Check rating

<table>
<thead>
<tr>
<th>Quality of services</th>
<th>Quality of financial management</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.E.A.K.</td>
<td>F.A.I.R.</td>
</tr>
<tr>
<td>G.O.O.D.</td>
<td>G.O.O.D.</td>
</tr>
<tr>
<td>E.X.C.E.L.L.E.N.T.</td>
<td>F.A.I.R.</td>
</tr>
</tbody>
</table>

This score covers a range of areas including safety of patients, cleanliness and waiting times

- More on quality of services

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>GOOD</td>
<td>GOOD</td>
<td>FAIR</td>
</tr>
</tbody>
</table>

This score looks at how well the organisation manages its finances

- More on quality of financial management

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>GOOD</td>
<td>FAIR</td>
<td>FAIR</td>
</tr>
</tbody>
</table>

Services Focused On

Table 13 – Bedford and Luton Community NHS Trust Health Check rating

<table>
<thead>
<tr>
<th>Community mental health services follow-up review</th>
<th>Published</th>
<th>NO COMPARATIVE ASSESSMENT</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>March 2009</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital services for people with acute mental health problems</th>
<th>Published</th>
<th>FAIR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>July 2008</td>
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</table>

<table>
<thead>
<tr>
<th>Adult community mental health services</th>
<th>Published</th>
<th>FAIR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 2006</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance misuse services</th>
<th>Published</th>
<th>GOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 2006</td>
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</table>
### What Patients Say

#### Inpatients: summary scores for patient survey questions

<table>
<thead>
<tr>
<th>Questions about…</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to the ward</td>
<td>6.2</td>
<td>About the same</td>
</tr>
<tr>
<td>The ward</td>
<td>7.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>7.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Nurses</td>
<td>6.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Medications</td>
<td>5.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>6.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Talking therapies</td>
<td>7.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Activities</td>
<td>3.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Physical Health Checks</td>
<td>6.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Rights</td>
<td>6.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>7.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall</td>
<td>6.0</td>
<td>About the same</td>
</tr>
</tbody>
</table>

*Table 14 – BLPT summary inpatient survey scores 2009*

#### Community based care: summary scores for patient survey questions

<table>
<thead>
<tr>
<th>Questions about…</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeing a psychiatrist</td>
<td>7.6</td>
<td>Worse</td>
</tr>
<tr>
<td>Seeing a community psychiatric nurse (CPN)</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Medications</td>
<td>6.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Counselling</td>
<td>6.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Patient’s care-coordinator</td>
<td>6.7</td>
<td>Worse</td>
</tr>
<tr>
<td>Patient’s care plan</td>
<td>5.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Care reviews</td>
<td>6.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Support in the community</td>
<td>4.4</td>
<td>Worse</td>
</tr>
<tr>
<td>Crisis care</td>
<td>4.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Information and support for families or carers</td>
<td>4.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>6.1</td>
<td></td>
</tr>
</tbody>
</table>

*Table 15 – BLPT summary community based care patient survey scores 2009*
3.7 Luton and Dunstable NHS Foundation Trust

### Table 16 – Luton and Dunstable NHS Foundation Trust Health Check rating

<table>
<thead>
<tr>
<th>Quality of services</th>
<th>Quality of financial management</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Circle Graph]</td>
<td>![Circle Graph]</td>
</tr>
<tr>
<td>This score covers a range of areas including safety of patients, cleanliness and waiting times</td>
<td>This score looks at how well the organisation manages its finances.</td>
</tr>
<tr>
<td>![Circle Graph]</td>
<td>![Circle Graph]</td>
</tr>
<tr>
<td>![Circle Graph]</td>
<td>![Circle Graph]</td>
</tr>
<tr>
<td>More on quality of services</td>
<td>More on quality of financial management</td>
</tr>
<tr>
<td>FAIR</td>
<td>EXCELLENT</td>
</tr>
<tr>
<td>FAIR</td>
<td>GOOD</td>
</tr>
<tr>
<td>GOOD</td>
<td>Good</td>
</tr>
</tbody>
</table>

Table 16 – Luton and Dunstable NHS Foundation Trust Health Check rating

### Services Focused On

<table>
<thead>
<tr>
<th>Children’s follow-up indicators</th>
<th>Published</th>
<th>NO COMPARATIVE ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>March 2009</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>January 2008</td>
<td></td>
<td>LEAST WELL PERFORMING</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>July 2007</td>
<td></td>
<td>NO COMPARATIVE ASSESSMENT</td>
</tr>
<tr>
<td>Admissions management</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>October 2006</td>
<td></td>
<td>EXCELLENT</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>October 2006</td>
<td></td>
<td>EXCELLENT</td>
</tr>
<tr>
<td>Medicines management</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>October 2006</td>
<td></td>
<td>FAIR</td>
</tr>
<tr>
<td>Services for children in hospital</td>
<td>Published</td>
<td></td>
</tr>
<tr>
<td>October 2006</td>
<td></td>
<td>FAIR</td>
</tr>
</tbody>
</table>

Table 17 – Luton and Dunstable NHS Foundation Trust Health Check rating
What Patients Say

<table>
<thead>
<tr>
<th>Questions about…</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The emergency / A&amp;E department, answered by emergency patients only</td>
<td>7.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting lists and planned admissions, answered by those referred to hospital</td>
<td>5.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting to get to a bed on a ward</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>The hospital and ward</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Doctors</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Nurses</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.1</td>
<td>Worse</td>
</tr>
<tr>
<td>Operations and procedures, answered by patients who had an operation or procedure</td>
<td>7.9</td>
<td>Worse</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>6.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>6.4</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Table 18 – Luton and Dunstable Hospital patient survey scores 2009

3.8 World Class Commissioning Patient Experience Metric

The proposed metric for patient experience is the self reported patient experience scores from the patient experience surveys carried out on behalf of the Healthcare Commission. It is proposed to use a composite score based on the primary care and acute inpatient scores. These are also Vital Signs (VSB15_01 and VSB 15_05).

The composite score will be the average (mean) of the acute inpatient score for the local acute trust and the primary care score for NHS Bedfordshire.

The 2007/08 provisional composite score for NHS Bedfordshire is 75.0 (78.1 for primary care and 71.9 for inpatients). This will provide a baseline against which to assess future performance.

The realignment of directorates, as part of our delivering our world class commissioning capability, has seen the establishment of a Directorate of Communications and Public Engagement. This dedicated resource signifies the importance NHS Bedfordshire places on putting patients and the public at the centre of all we do. Our Communications and Engagement Strategy sets out additional measures and processes for gaining a deeper insight into patients’ views, preferences and experiences. It is attached as Appendix H.
3.9 PALS Enquiries and Complaints

NHS Bedfordshire operates a successful Patient Advice and Liaison Service (PALS) that is fully integrated with the complaints office. PALS staff handle 700-800 enquiries each year. PALS is the first point of contact for many patients who are unhappy about the service they have received, or who simply require advice, assistance or reassurance. Patients can contact the service in a number of different ways: face to face or by telephone, email, letter, fax or through a dedicated PALS link on our website.

Investigating and resolving patients’ concerns through PALS provides for a speedier alternative to the formal complaints procedure and often helps to avoid concerns escalating into formal complaints.

All enquiries and complaints are logged on specialised software that helps us to monitor trends in service areas. Reports are made quarterly to the Board and also to different quality monitoring committees to highlight important issues, how they have been addressed and to identify gaps in service. PALS shares feedback at regional and national levels to identify trends within the East of England and wider areas.

The NHS Constitution states:

Patients have the right:

- To have any complaint they make about NHS services dealt with efficiently and to have it properly investigated
- To have the right to know the outcome of any investigation into their complaint
- To have the right to take their complaint to the independent Health Service Ombudsman, if they are not satisfied with the way their complaint has been dealt with by the NHS
- To have the right to make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body
- They have the right to compensation where they have been harmed by negligent treatment.

There has been a year-on-year fall in the number of formal complaints from 50 in 2005/06 to 38 in 2006/07, 34 in 2007/08 and 30 in 2008/09. This may be seen as reflecting the effectiveness of PALS in securing early resolution of issues raised by patients.

However, the nationwide introduction of new complaints procedures in April 2009 provides the opportunity for us to investigate complaints, not only about services that we provide, but also about all services that we are responsible for funding. This has already begun to effect a steady rise in the total numbers of complaints being recorded. Whilst this is anticipated to increase substantially the level of work for the department, it is not anticipated that the overall level of complaints against NHS Bedfordshire will increase.

We record where there has been a specific service change as a result of PALS contacts and complaints. This has been evidenced in service delivery in community
health services and we are now starting more detailed engagement with commissioners. In particular, reports are produced on a quarterly basis to the commissioning senior managers meetings, which highlights the types of enquiries by PBC area.

The PALS team has also been involved in ensuring that patient experience is considered in the review of NHS Bedfordshire’s exceptional treatment process. PALS and complaints now features within the process and the team works with commissioning managers in identifying trends.

PALS feedback has influenced commissioning decisions and service changes. For example, PALS enquiries identified a gap in NHS dental provision in Leighton Buzzard. This formed part of the evidence that enabled the trust to support the opening of a new practice in the town in 2008.

**3.10 Comment Cards**

Comment cards are available in all health centres and are distributed by frontline staff with patient information materials. These cards were also used widely during the operation of our swine flu anti-viral collection points. The comment cards enable patients to rate services and to add their comments on all aspects of the service that they have experienced.

Where a particular problem or trend is identified, the PALS team contact those patients who have completed a card in that respect to thank them and to provide details of what action has been taken as a result. Where appropriate comments are shared with the services to which they relate and are reported in quarterly reports in order to close the loop in patient feedback.

**3.11 Listening to and Supporting Carers**

At a workshop on 13 July 2009, carers told Central Bedfordshire Council and NHS Bedfordshire what their local priorities were in response to the new National Carers Strategy and a review of local carers services and needs by Carers UK.

NHS Bedfordshire and Central Bedfordshire Council have developed a joint plan for 2009-10 to provide breaks and support to carers using new NHS funding for carers and Central Bedfordshire Council’s carers grant. The plan’s outcomes are to:

- Treat carers as expert care partners
- Provide access to information and personalised services
- Enable carers to have a life of their own outside of the caring role
- Support carers to avoid financial hardship because of their caring role
- Promote the mental and physical well-being of carers
- Protect young carers from inappropriate caring roles.

NHS Bedfordshire and Central Bedfordshire will work together and with carers and partners in third sector organisations to deliver these outcomes:
• Both organisations are members of the Eastern Region Carers Leads Network.
• Central Bedfordshire Council and NHS Bedfordshire will work together to commission carers services in the third sector.
• Central Bedfordshire Council will chair and NHS Bedfordshire will vice-chair, the Carers Delivery Group, monitoring the delivery of services to carers and will report to the Healthier Communities and Older People’s Partnership Board.
• Both organisations will recognise and value carers as expert care partners in service planning and delivery through the Central Bedfordshire Carers Forum, which links to the Carers Delivery Group.

3.12 Developing Delivery and Improving Practice in Assessment

Practice Based Commissioning (PBC) will continue to play a key role in the delivery of our strategy as well as in the wider NHS system reform. PBC groups enable primary care clinicians to commission appropriate healthcare services to meet the need of their local populations. PBCs will use their knowledge of the healthcare requirements of their patients coupled with robust local health needs assessment to improve patient care and outcomes and ensure that the best possible value is derived from available financial resources. This will effectively deliver NHS Bedfordshire’s strategic vision.

We are committed to improving individual needs assessment and provision of advice, support and guidance for carers across Bedfordshire, involving them more centrally in a caring role with service users. This will require considerable practice change.

We will employ practice development workers to raise awareness with the multidisciplinary teams and with carers to accelerate and enable this carer focus. They will model good practice and facilitate change over a three year period, exploring the needs of carers, sourcing information, providing training and building networks.

During this time we would expect to see a considerable change in practice, resulting in new deals for both carers and patients.

3.13 Ongoing Clinical Engagement and Clinical Leadership

Clinical engagement and clinical leadership is essential in commissioning effective services. It is recognised that clinicians have the vision to redesign services to ensure they are both responsive and effective.

Strong clinical leadership is also vital to effect transformational changes which help to overcome barriers across organisations both within and outside of the NHS. Clinicians are uniquely placed to lead change by utilising evidence based practice and challenging perceived wisdom, whilst keeping the focus on the patient.

Clinicians have been engaged in redesigning services and providing better care for the population of Bedfordshire. Examples include:

• Consultant cardiologists from both Bedford and Luton and Dunstable hospitals are working on a joint pathway for PCI development in Bedfordshire, subject to accreditation.
There is strong clinical engagement at the Acute and Urgent Care Project Board and work streams, with doctors and nurses from both the hospital and primary care. There have been a number of workshops both in the north and south of the county to help redesign pathways for 24/7 urgent care.

NHS Bedfordshire is working closely with the Anglia Cancer Network and Mount Vernon Cancer Network in redesigning cancer care pathways. NHS Bedfordshire works particularly closely with cancer clinicians from Bedford Hospital in redesigning and delivering effective and clinically appropriate cancer services.

Bedfordshire Locality Cancer Group is engaged in redesigning the cancer care pathway.

North Bedfordshire and south Bedfordshire diabetes networks are engaged in redesigning the diabetes care pathway.

South Bedfordshire Clinicians Group is engaging in dialogue between GPs and consultants at Luton and Dunstable Hospital.

Bedfordshire and Hertfordshire Priorities Forum is engaged in defining the clinical priorities and access / exit criteria for services in the region.

Bedfordshire and Luton Joint Prescribing Committee is engaged in implementing a clinically effective and cost effective prescribing policy for the region.

Bedford Hospital Quality Committee is engaged in trying to provide better quality healthcare for the patients of Bedford Hospital.

Bedfordshire and Luton Programme Management Board for diabetic retinopathy screening ensures that national screening programme quality assurance standards are met.

Bedfordshire and Luton Programme Management Board for the bowel cancer screening programme ensures quality assurance standards are met.

Bedfordshire and Luton Programme Management Board for the breast cancer screening programme ensures quality assurance standards are met.

There is a vascular network in place, covering Bedfordshire and Hertfordshire which includes clinicians and commissioners and which is instrumental in planning for the abdominal aortic aneurism (AAA) screening programme.

GPs have been engaged in designing the PCT’s ‘End of Life’ strategy.

There has been clinical engagement with Bedford Hospital in trying to reduce the hospital’s mortality rates.

The Medical Director from Bedford Hospital chairs the Children’s Clinical Services steering group, which is also attended by three or four other clinical consultants.

Consultants, health visitors and midwives attend the Maternal Mental Health Group. The Maternity Services Liaison Committee has an obstetrician, a paediatrician, midwives and health visitor among its members.

Our Professional Executive Committee (PEC) plays a key role in further supporting this approach. Within NHS Bedfordshire all PBC lead clinicians are members of the PEC, with additional support from PBC chief officers.
PEC clinicians act as clinical champions and sit on key committees, as do other clinicians. This ensures that clinicians are involved in developing Bedfordshire wide strategies, policies and service redesign and making sure they are then implemented to reflect local needs.

We will continue to explore if there are other or better ways to communicate with our local clinical colleagues and to identify any areas of work that would benefit from clinical representation from the PEC.

### 3.14 Engagement with Our Partners

The aspiration to improve health and well-being in Bedfordshire and decrease health inequalities is shared by all key partners across Bedfordshire. This shared aspiration is currently articulated in Bedford Borough’s Sustainable Communities Strategy and in Central Bedfordshire’s Comprehensive Area Assessment.

From 1 April 2009, the current targets within the Local Area Agreement were disaggregated in line with the establishment of two new unitary authorities for Bedfordshire – Central Bedfordshire and Bedford Borough. NHS Bedfordshire leads on reduction of smoking, decreasing childhood obesity, improving life expectancy and reducing health inequalities. A local priority is increasing the percentage of drug users engaged with treatment.

Achieving these goals will require changes in how we provide health care services and how we work with partners. Each of the unitary authorities are in the process of establishing their own strategic vision for health and social care, and NHS Bedfordshire has been working closely with both unitaries to ensure that everyone in Bedfordshire, particularly the most vulnerable groups, has access to high-quality health and social care services when they need them and the help they need to lead healthy and independent lives.

### 4. So What Do We Need To Do?

Three strategic priorities will drive our implementation plans:

- **Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).**

- **Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need.**

- **Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.**
4.1. Investing a Greater Proportion of Our Money into Prevention

The NHS must invest in prevention, not just catch people when they fall ill. A significant percentage of the changes set out in NHS Bedfordshire’s implementation plans support prevention. See Appendix A. We will:

- Support more people to give up smoking working with primary care, pharmacists, hospital and local communities. We will target areas of deprivation to drive down health inequalities.
- Reduce childhood obesity working with schools and their local communities to remove the factors that promote obesity and promote factors, such as exercise, which reduce it.
- Identify people at risk from heart disease and provide advice and treatment to reduce their risk. Again there will be specific initiatives in areas of deprivation to drive down health inequalities.
- Help people to book early when they know they are pregnant so they can access the full range of advice and support.
- Support carers to enable them to continue to support the people they care for even during complex times.

What Success Will Look Like in 2013/14

Users’ perspective
I’ve been encouraged and supported to be as healthy as possible. This support has extended across my whole family. With help and support, I have been able to give up smoking. My husband was a heavy drinker. He has been given the information to help him understand what is happening to him from drinking too much alcohol. I buy more fruit and vegetables as a result of being given help to understand why the food my family choose to eat can affect how we feel. My little girl is able to attend an exercise class to help her lose weight and keep her fit.

Clinicians’ perspective
Prevention is now embedded into the care pathway. It’s rare for me now to operate on someone who hasn’t managed to give up smoking before their operation. Infection rates and complication rates are down. While I am still seeing obese patients, the rise in numbers seems to have stabilised. It is encouraging to see that more and more patients, especially the young, are really starting to understand how weight can affect their health in the future.

Commissioners’ perspective
Prevention is embedded into contracts. Commissioning is based on outcome and this includes improvement in healthy lifestyles and patient experience. We commission activity that, only a few years ago, would have been seen as outside the scope of the NHS, such as exercise classes and healthy eating support groups.
4.2. Creating Effective Support in Local Communities

The fundamental role of the hospital and specialist acute services in treating patients needs is crucial but there are many areas where services could and should be provided outside of a hospital setting, closer to peoples homes. Many of the actions set out in our implementation plans will support this shift in the care setting. We will:

• Increase capacity within primary and community services
• Invest in the infrastructure of primary care to support the transfer of services to high quality, locally based care
• Develop direct access to diagnostics and availability of results prior to consultant appointment, including community based diagnostics
• Intervene early in primary care when people have mental health problems through initiatives such as Increased Access to Psychological Therapies (IAPT)
• All planned services will be accessed within the clinically appropriate waiting time – a maximum of 18 weeks
• Improve access to specialist services for assessment and treatment for children, particularly therapy services
• Offer more choice to women about how they access antenatal and postnatal services
• Ensure end of life care is well co-ordinated and delivered seamlessly, with the emphasis on improved communication
• Develop 24/7 rapid access to community nurses, backed by specialist advice to enable patients to die at home, if that is their choice.

What Success Will Look Like in 2013/14

Users’ perspective
My mum is 90 and we know that she is getting weaker and old age is catching up on her. We live about an hour’s drive away from the hospital where she normally goes. She never liked being there; it was lonely for her because it was difficult for us to see her every day. It was sad for my grandmother who passed away 20 years ago, alone in her hospital bed without her family around her. I am so glad it won’t be like that for my mum because we have her at home, where she wants to be. We get to see her every day. It’s really good to see everybody helping us to give mum what she really wants.

Clinicians’ perspective
As a GP, I have the confidence to manage complex patients in the community as I can access the diagnostic and nursing support I need when I need it and patients can quickly access specialist support when they need it. Where appropriate and where needed, the services have become well integrated and patients are getting increased access to care, especially during evenings and weekends. I have greater access to
increasingly sophisticated technology, which allows me to be mobile and take care to the patients in a way that is safe and allows care to be provided in places that were just not possible in the past.

**Commissioners’ perspective**
The role of the hospital has changed; they are doing what they do best and care for patients with more complex and acute needs. The rest is carried out in the community. We commission local services for local people; we consider the health inequalities of the local people and the fairness of health provision when we provide those services. We have a wide range of contracts with providers; many of which are now jointly provided with the local authority. These are underpinned by appropriate system wide estate facilities and IT. We use feedback from patients, carers and clinicians to continually drive up the range and quality of these services. We work with the local population to plan the changes that will enhance and improve the outcomes for patients.

### 4.3. Ensuring that the People of Bedfordshire Have More Choice and Convenience

Choice must be available across the whole life pathway, from the choice of where to give birth to supporting the increasing number of people who want to die at home. There are many initiatives within the implementation plans aimed at increasing the choice of services available to the people of Bedfordshire. We will:

- Commission multiple providers of IAPT
- Roll out of the Choose and Book system to non consultant led services
- Develop midwifery led units
- Move more care into the community with a range of providers
- Utilise the ‘in control’ programme for people with complex health and social care needs. This allows them to direct how NHS and social care money is spent to meet their needs
- Roll out personal management plans to help people with long term conditions to understand and make best use of the range of services available to them
- Continue to develop the expert patient programme that has been specifically developed for people living with long-term conditions. The aim of this lay led self-management programme is to support people to increase their confidence, improve their quality of life and better manage their condition.
What Success Will Look Like in 2013/14

Users’ perspective
I used to think choice was just about which hospital provided treatment. I now know that it’s also about how I am cared for and the options for the different treatments. I can choose from a menu of options that might be appropriate to me. It is nice to be recognised as a person rather than a clinical condition and it’s nice to know that I have been consulted about benefits and risks because, after all, I’m the best person to make the choice about what’s right for me.

Clinicians’ perspective
When I used to ask people which treatment option they preferred I’d often be told “you know best”. Now, with the new information and ways of communicating risk, more and more people are able to choose for themselves. It’s important that my patients can get information about their condition and treatments that allow them to make a real informed choice. I feel as though I am in partnership with the patient when they are choosing what is right for them, rather than me telling them what is right for them.

Commissioners’ perspective
Choice is driving quality and reducing health inequalities. By commissioning health trainers, expert patient programmes and setting standards for personal management plans, we are ensuring everyone has access to choice, not just about where they are treated but also how.

5 Existing Targets, Local and National Priorities

NHS Bedfordshire began this year in financial balance and with relevant performance measures in place to ensure the organisation is on course to achieve ‘balance’ year-on-year. NHS Bedfordshire has focused priorities set out in the Operating Framework including:

- Improving cleanliness and reducing healthcare associated infections.
- Improving access through achievement of the 18 week referral to treatment pledge, improving access (including at evenings and weekends) to GP services.
- Keeping adults and children well, improving their health and reducing health inequalities.
- Improving patient satisfaction, experiences and engagement.
The NHS Operating Framework set priorities over a three-year spending period, 2008/09 to 2010/11 and the accompanying planning guidance set out the specific deliverables and milestones that PCTs are required to include in their operational plans for 2008/09.

NHS Bedfordshire is also required to measure progress made against a set of indicators called the ‘vital signs’. The vital signs include measures of progress against the national priorities, as well as a broader set of health indicators, for benchmarking. This enabled us to decide on local priorities.

There is also a requirement to deliver new commitments by 2010/2011, including national strategies for stroke and cancer. We also need to continue delivering on existing national targets, for example, 98% of patients to be seen in A&E in less than four hours. Maintaining standards at national level is a minimum requirement and tackling variation in performance locally is essential for NHS Bedfordshire.

We aim to ensure that local people receive the standards of care they expect from the NHS.

We monitor performance robustly and ensure that contractual targets are met and to the quality expected.

We provide performance reports to our Board at every Board meeting and also to sub committees of the Board for scrutiny. These report progress for all performance indicators and exception reports in detail. Our reporting matrix aims to give greater consistency and transparency in its approach to tackling underperformance, supporting recovery and holding all commissioned service providers to account.

We want to achieve continuous improvement in all areas of service delivery and have introduced ‘balanced scorecards’ for all service providers. This has given us a way of ensuring that our strategies and detailed plans have been thought through and visibly linked to wider goals. It is a system for managing the performance in delivering services to the public of Bedfordshire.

The underpinning approach in relation to the development of the balanced scorecard is about more than simply measuring performance. It is about aligning the organisation’s overall vision, key strategic actions, performance measures and performance management. This is set out in our Operational Plan 2008/09, attached as Appendix C.

We will identify areas of good practice/innovation as well as identifying areas that have not reached the required performance level.

Our performance against targets is included as Appendix E.
5.1. Bedfordshire’s Local Area Agreement 2008-2011

The new Local Area Agreement (LAA2) is a three year agreement between central government, local authorities and their partners that operates from June 2008 to March 2011. The Local Area Agreement operated at a county-wide level in year one, but targets are disaggregated to reflect the boundaries of the two new unitary councils from April 2009.

The vision is for Bedfordshire to be an even better place to live, work and visit. This vision will be achieved by delivering the following priorities:

- Growing our economy and raising the profile and identity of the county as a great place to live
- Protecting and enhancing our environment, green infrastructure and spaces, promoting sustainable housing growth and preparing for climate change
- Raising the aspirations of our children and young people
- Building cohesive, strong, safe and sustainable communities with well planned, decent and affordable housing, where people have a shared identity and sense of belonging
- Reducing health inequalities and delivering good health and well-being for our communities.

Key health and social care priorities and targets include:

- NI51 To increase the effectiveness of children and adolescent mental health services
- NI56 To reduce the number of children in year 6 who are obese
- NI115 To reduce substance misuse by young people
- NI120 All age cause mortality rates – to increase healthy life expectancy and reduce inequalities in health
- NI123 To reduce age 16+ current smoking prevalence
- NI130 To increase the number of social care clients receiving self directed support
- NI135 Increase the number of carers receiving needs assessment or review and a specific carer’s service or advice and information
- NI141 To increase the percentage of vulnerable people who have moved into independent living
- NI142 To increase the percentage of vulnerable people who are supported to maintain independent living.
6. Our Track Record of Success

NHS Bedfordshire has an ongoing track record of achievement since its inception in October 2006. It has the capability and skill to continue to deliver complex and innovative change.

6.1. Financial Turnaround

NHS Bedfordshire delivered a Turnaround programme amounting to £37m in 2007/08 and ended the year with a surplus of £133,000 on a resource limit of £474m. This followed a deficit of £17.6m on a resource limit of £416m in 2006/07.

Systems and processes were changed and a more rigorous approach to budget management was introduced. All of the lessons learned from turnaround have been embedded in the organisation in 2008/09. One of the results of the improved approach to financial management was an improved use of resources rating in the 2008 Annual Health Check.

6.2. 1Call: Reducing Unnecessary Emergency Admissions

The Practice Based Commissioning (PBC) groups commissioned a new service to provide a single point of contact for healthcare professionals requiring urgent care for their patients. Through analysis of SUS data, reviewing case management of ‘frequent flyers’ and seeking the views of primary care professionals and patients, the PBCs determined that urgent community care was difficult to access, with 66 different routes of access. This led to many patients unnecessarily accessing emergency care and many being admitted as a result.

By taking access points from 66 down to one, through implementation of 1Call, a single local call number, this has reduced unnecessary admissions to hospital and meant that more patients have been able to be cared for at home. By the 1 September 2009, the service had dealt with 15,724 referrals and messages from health and social care professionals, carers, relatives and patients.

In line with our strategy, this service has been commissioned as a joint venture between the East of England Ambulance Trust and the Bedfordshire Community Health Services in order to encourage plurality of provision and support NHS Bedfordshire’s strategic priorities. Services currently available through 1Call:

- IAPT
- Palliative care
- Community matrons
- Community nursing
- Rapid intervention
- Community beds
- Rehabilitation and enablement.
6.3. Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies (IAPT) programme is a Department of Health initiative to improve access to psychological (talking) therapies and will support the implementation of stepped care (NICE).

In September 2008, the IAPT service was introduced across NHS Bedfordshire to provide early and swift access to psychological therapy in the primary care environment and to implement the NICE guidance for people suffering with depression and anxiety disorders.

Since the launch of the service and the end of August 2009, 538 service users completed their treatment and of those, 71% demonstrated measurable improvement in their mental health and wellbeing. This is supported by the following patient statement, which is representative of the feedback received:

“The difference is brilliant; I don’t feel like I need to be dead anymore, which is a major step. I don’t feel I’m worthless. I feel I belong somewhere.”

6.4. Improving Community Health Services

PBCs, working closely with the Bedfordshire Community Health Services management team, reviewed community nursing and intermediate care services and recommended changes that have recently been implemented. The outcome was to ensure that commissioned services promote faster recovery from illness, prevent any unnecessary acute hospital admission, support timely hospital discharge and maximise independent living. The reviews involved extensive clinician and patient engagement and led to revised service specifications and through partnership working, the PBCs have successfully delivered a new model of service provision.

6.5. Improving Access to General Practice

NHS Bedfordshire opened the first Darzi health centre in the country.

The GP walk in Medical Centre at Putnoe has proved to be a success with the residents of Bedfordshire. The Centre has patients accessing the service from eight to eight seven days per week, with high numbers attending.

In addition, we have 69% of our GP practices signed up to provide extended hours as identified in the patient survey.

We also intend to work with the Improvement Foundation to assist practices experiencing difficulties in meeting the access requirements of the PCT, as indicated by their patient survey.

6.6. Improving Access to Dentists

NHS Bedfordshire is committed to ensuring that everyone in the population it serves will be able to access an NHS dentist, if they wish. To ensure this pledge, we have:
• Comissioned a new dental practice in Leighton Buzzard
• Increased existing NHS dental contracts across the whole of Bedfordshire to enable dentists to treat new patients
• Carried out an advertising campaign to inform patients of accessibility and costs of NHS dental treatment
• Established a dedicated telephone line for access queries
• Embarked on a project to raise awareness of the availability of NHS dental services across the county.

6.7. Improving Mental Health and Well Being

The key driver for the Healthier Steps to Employment project is to support people on incapacity benefit to understand and better manage their health condition, so that they can successfully return to work. The project was established between NHS Bedfordshire, Job centre Plus, the local authority and a range of voluntary sector organisations last year. The health and well being programme includes opportunities for referral to pain management sessions, support for mental health conditions and physical activity sessions.

6.8. Improving Access to Local Care

Over the last 18 months, our PBCs have established a number of services that allow people to access assessment and treatment locally rather than attending hospital. Examples of this are:

• In West Mid Beds a number of ‘closer to home’ services have been developed that have improved access and enhanced patient experience. They are:
  o Consultant led ophthalmology as a one stop service at Ampthill
  o Practice based 24 hours ambulatory cardiac monitoring service
  o A range of GPSI services available to all patients in the locality: a musculoskeletal service at Flitwick; a dermatology service at Ampthill (including a two-tier skin service); and an ENT service at Ampthill.

• Horizon Healthcare in Bedford have designed and commissioned an evidence based community pulmonary rehabilitation service (on behalf of Horizon Health Commissioning, West Mid Beds and Ivel Valley Health Partnership).

• Horizon Health have also designed and commissioned a much needed home oxygen service for the population of north Bedfordshire. This service has saved approximately £125,000 since it began in March 2008.
7. Provider Landscape

NHS Bedfordshire commissions services from a wide range of providers to ensure that the population receives NHS Services free of charge, apart from certain limited exception sanctioned by Parliament.

These services have traditionally been segmented as secondary care, mental health, primary care and community services. However, as we move forward it will be important to overlay this understanding with an understanding of provision by clinical pathways and by programme budgets.

NHS Bedfordshire will promote choice in provider of care with the right access NHS Services that are not refused on unreasonable grounds.

Bedfordshire residents are already able to access a wide range of providers, especially from secondary care. Although there are a number of general and specialist providers this does not always correlate with quality of provision.

The 2007/08 Health Commission (HCC) ratings identify a range of weaknesses across our provider landscape.

Some acute trusts are not currently on target in relation to reduced Healthcare Acquired Infection. This needs to be resolved.

The NHS Constitution states:

NHS services are generally provided free of charge. This includes access to local services like your GP, hospital or clinic, so you do not have to worry about payment. There are some exceptions: for example, some people will have to pay for prescription charges and visits to the dentist. Overseas visitors may also have to pay charges.

NHS services will always be available for the people who need them. NHS Bedfordshire will not deny the right to access these services because of race, religion or belief, gender, disability or sexual orientation – these are all ‘unreasonable grounds’ on which to refuse patients access. ‘Reasonable grounds’ to refuse access to the NHS include abusive or violent behaviour by the patient, for example.

Access to NHS services is not denied in situations where patients pay for additional private care separately. Further information is set out in the Government’s response to Professor Richards’s report, improving access to medicines for NHS patients (2008).

Patients have the right to accept or refuse treatment that is offered to them, and not to be given any physical examination or treatment unless they have given valid consent.
If patients do not have the capacity to do so, consent must be obtained from a person legally able to act on their behalf, or the treatment must be in their best interests.

Patients have the right to be given information about their proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing.

The NHS commits to continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments.

All NHS organisations work to improve the quality of the services they provide or commission, including by assessing clinical and service innovations relevant to their clinical responsibilities. In 2008, the Department of Health and the NHS agreed a more ambitious vision for making quality improvement the organising principle of everything the NHS does. High Quality Care For All defined quality as having three dimensions: ensuring that care is safe, that it is effective, and that it provides patients with the most positive experience possible. These three dimensions of quality are being placed at the core of everything the NHS does – both as ends in themselves, but also because delivering the best quality of care will ultimately ensure that the system as a whole gives best value.

The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.

This pledge goes beyond the specific legal requirements for NHS bodies. For example, in committing to ensure that its facilities are fit for purpose, the NHS recognises that the quality and design of buildings and their upkeep have a material impact on the health and well-being of those using them – both public and staff. Specific legal requirements are set out in health and safety legislation and the law relating to negligence. Requirements are also made clear in the duty to provide and maintain a clean and appropriate environment for healthcare, as set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infections. All acute trusts are inspected against this code of practice by the regulator, currently the Healthcare Commission and, from April 2009, the Care Quality Commission.

This pledge focuses on those things that the NHS commits to do alongside or in addition to its legal requirements. In particular:

NHS organisations should take account of the series of specifications and guidance that describe how to provide a clean and safe environment for patient care. For example, the National Specifications for Cleanliness in the NHS set out the standard of cleanliness expected, as well as suggesting the frequency of cleaning needed across the NHS. National best-practice guidance for the design and operation of healthcare facilities ensures that the NHS has the information it needs when refurbishing or rebuilding its facilities to meet both clinical requirements and patients’ expectations that their privacy and dignity will be respected and their comfort assured.

The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.
The UK National Screening Committee is the national advisory body for the Government and the NHS. It advises on which screening programmes to introduce nationally, taking into account issues such as safety, quality, and clinical and cost effectiveness. It also supports the implementation, development and quality assurance of screening programmes.

Screening has the potential to save lives and improve quality of life through the early diagnosis of conditions. Screening can reduce the risk of developing a condition or its complications. Two examples include:

- Approximately 4,500 women’s lives are saved each year in England because of cervical cancer screening.
- 1,600 newborn babies are screened for hearing impairment every day, identifying problems two years earlier than previous methods and safeguarding educational and social development.

7.1. Driving Up Quality and Safety

NHS Bedfordshire embraces the vision set out in ‘High Quality Care for All’ and has already done much to support the vision becoming a reality in Bedfordshire. A system of monitoring the quality of providers has been in place since April 2007 as part of provider’s contracts which has been developed by clinical leaders within NHS Bedfordshire and utilises Standards for Better Health as a framework.

This allows the PCT to review key safety, quality and patient experience metrics on a regular basis with providers, to identify concerns and ensure action is taken to improve.

This enables NHS Bedfordshire to have a clear approach to quality improvement and ensures that we utilise staff with the right skills to support improvement.

This has also enabled us to set local as well as national measures and which supports the new national quality metrics and Patient Reported Outcomes Measures.

This provides regular reports containing quality information for review by both clinicians, providers and commissioners, benchmarked where appropriate, which helps identify areas where improvement is required.

The agenda is challenging locally, with further improvement still required in relation to reducing Health Care Acquired Infection and ensuring high quality mental health services continue to be provided through transition. We have also set targets to further reduce Hospital Standardised Mortality Rates.

However, work already undertaken has ensured that providers are working with us in an open and transparent way to make improvements. Building on the existing quality framework, NHS Bedfordshire will hold all providers to account against increasingly stringent standards for quality and safety.
In the future:

- NHS Bedfordshire will ensure our residents are aware of the strengths and weaknesses of providers by making information available on NHS Bedfordshire’s website, local papers, within surgeries, clinics and local libraries, thus promoting informed choice and driving up the quality of our providers.
- Developments in primary and community settings will ensure there are more providers in the market, so choice will increase.
- To further improve choice and stimulate the market, we will consider utilising capacity in private and voluntary providers.
- We will develop care pathways across a range of services in primary and secondary care that provide safe effective high quality, evidenced base care that improve quality, access and outcomes for the population. These pathways will also deliver value for money and ensure we use geographical networks, as appropriate.
- We will ensure that the privacy and dignity of patients is maintained at all times. Much work has already been done by NHS Bedfordshire and its providers to ensure patients are not cared for in mixed sex accommodation.
- Patients will have the right to access their own health records.

As well as ensuring effective and safe care, we need to ensure locally that patient experience and the quality of care people receive are also of paramount importance.

We will utilise the existing quality frameworks, including the Quality and Outcomes Framework and the balanced scorecard for GPs, in order to drive up quality in primary care. We will utilise the NHS Bedfordshire quality schedule for commissioned contracts. We will also work with providers to ensure that quality accounts and incentive payments we are using within contracts for quality to make a real difference.

These tools are to monitor and drive improvements in clinical quality and patient experience. Ensuring privacy and dignity, care closer to home and the patient’s choice, needs and preferences, are key elements within this. We will set challenging targets and robustly monitor progress in these areas. Good progress is already being made, as shown by CQC outcomes for Standards for Better Health, which reflect the hard work and the improvement made by local providers in relation to this agenda.
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Table 19 – CQC ratings 2009 and previous years' HCC ratings
7.2. Relationship with Other Commissioners

We will focus on sharing information to drive forward change, to improve quality and accommodate the strategic direction of all commissioners. This will also take into account the requirements of practice based commissioning groups as key partners in commissioning.

We will ensure that we appropriately inform lead commissioners of our requirements and in return, we expect them to represent these in negotiations with providers.

7.3. Acute Hospital Providers

The largest share of secondary care provider services within the boundaries of NHS Bedfordshire is Bedford Hospital NHS Trust. The trust operates services from a number of sites, but primarily from Bedford Hospital.

NHS Bedfordshire currently commissions £104m worth of acute care services from Bedfordshire Hospital NHS Trust. This constitutes over 46% of the total spending of £225m on acute service by NHS Bedfordshire, excluding specialist commissioning.

Other local providers of secondary care for the NHS Bedfordshire include:

- Luton and Dunstable NHS Foundation Trust
- East and North Hertfordshire NHS Trust
- Cambridgeshire Universities NHS Foundation Trust
- Milton Keynes Hospital NHS Foundation Trust
- Buckinghamshire Hospital NHS Trust
- London acute and specialist providers.
7.4. Access to Acute and Specialist Services

By analysing programme budget expenditure against clinical pathways, NHS Bedfordshire will be able to review current care delivery models and identify where shifts of activity are intended. This will in turn stimulate market development and facilitate change in the future provider landscape. NHS Bedfordshire will take steps to proactively communicate and publicise new provider market opportunities.

NHS Bedfordshire will decommission certain activities to reshape provision as the move to relocate services into the community picks up pace.

There are still a number of patients attending London hospitals who could benefit from having care provided closer to home. This activity could be commissioned from services more accessible to Bedfordshire residents. A number of trusts are looking at their portfolio of services and have expressed interests in undertaking more specialist activity. These aspirations will be managed to ensure supply does not significantly outstrip demand.

Agreement for collaborative working has been reached across the Bedfordshire, Luton, Buckinghamshire, Northamptonshire and Milton Keynes catchment population.

There is considerable scope to improve services to patients by improving the quality and productivity of services across commissioning portfolio’s. Joint planning and delivery mechanisms are being established by the MKSM growth Programme Board,
to ensure sustainable services across acute and planned care. In partnership with Local Authorities and Ambulance Trusts and other stakeholders.

7.5. Strategic Priorities and Implications for the Acute Market

NHS Bedfordshire’s priority is to drive the benefits from competition to achieve a consistent high quality of provision and strong performance against key performance indicators from all our key providers and to offer high quality choice.

We will need to use all the contracting mechanisms available to us to achieve these aims. Where appropriate, we will market test services, both in response to identified problems but also to stimulate innovation, increase patient choice and drive up standards.

We will continue to work effectively with other lead commissioners. It will also be important that the PCT continues to use choice as a key mechanism for delivering quality improvements.

Market Development is another key lever which in turn will enable us to stimulate change and drive up quality. NHS Bedfordshire has started to work with new providers and will continue to do so to enable new skills and expertise to re-energise the health system.

NHS Bedfordshire will work with providers to ensure contracts are linked to care pathways through programme budgeting and will ensure providers report activity and outcomes against the 23 programme budgets.

7.6. Community Services

NHS Bedfordshire has committed to spend an additional £46m to increase capacity within primary and community care services.

NHS Bedfordshire will proactively stimulate the market to ensure that we commission a range of effective community services that support the shift of emphasis from acute care.

Services currently provided by Bedfordshire Community Health Services will be covered by waiting time guarantees from April 2009. These include:

**Adult:** Acquired Brain Injury, Nutrition and Dietetic Service, Podiatry, Continence, Occupational Therapy, Community Nursing, Intermediate Care, MacMillan Nursing, Neurorehabilitation, Speech and Language Therapy

**Child:** Nutrition and Dietetic Service, Podiatry, Continence, Paediatric Medical Service, Paediatric Community Nursing, Health Visiting, Intermediate Care, School Nursing, Speech and Language Therapy.
Providers of Primary Care

The NHS Constitution states:

Patients have the right to choose their GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case the patient will be informed of those reasons.

Patients have the right to express a preference for using a particular doctor within their GP practice, and for the practice to try to comply.

Patients have the right to make choices about their NHS care and to information to support these choices.

We have 277 GPs in 58 practices across NHS Bedfordshire. Of these, 27 practices operate under the nGMS (new general medical services contract), 28 are PMS (personal medical services) practices, two are APMS (alternative provider medical services) and one is PCTMS (PCT medical services).

General practitioners in Bedfordshire are formed into four practice based commissioning (PBC) groups and a number of individual practiced based commissioners.

GPs, practice nurses and teams are required to provide essential and additional services under the terms of their contract. These are defined as:

- Cervical screening services
- Child health surveillance services
- Minor surgery
• Maternity medical services (excluding intrapartum care)
• Contraceptive services
• Childhood immunisations and vaccinations.

Enhanced services are commissioned separately. These are broken down as follows:

• Directed Enhanced Services  PCTs must commission these but GPs do not have to provide them.
• National Enhanced Services  PCTs may commission according to local priorities. GPs can choose to provide them.
• Local Enhanced Services  Developed and agreed locally by PCTs together with GPs.

There are 26 dispensing practices serving rural areas where a pharmacy may not be viable and 23 training practices across NHS Bedfordshire.

The majority of general practice services in Bedfordshire are developed from premises owned and maintained by GPs. The primary care estate is variable in quality and much is no longer fit for purpose.

In areas of high demand new models of commissioning primary care access are being considered alongside the premises redevelopment. For example, early engagement with the population on the new Station Quarter premises redevelopment has shown that one priority is a walk in centre. Therefore, in areas of high demand and deprivation, additional resources will be invested to address health improvement and reduce inequalities.

We will utilise all available contract levers, outcome measures, patient satisfaction measures and available quality measures in order to drive up the quality of providers of primary care. A balanced scorecard and set of key performance indicators have been developed which identify initial standards required.

Shortfalls in GP premises and facilities capacity was measured and quantified in 2007. LIFT was established in July 2008 as the delivery vehicle to work alongside other procurement of capacity routes.

NHS Bedfordshire has identified insufficient primary care capacity and in response a major improvement programme is in development, including the potential to improve and expand primary care facilities in:

• Queen’s Park, Bedford
• Goldington, Bedford
• Shortstown, Bedford
• Cauldwell, Bedford
• Bedford town centre
• Kempston
• Cranfield
• Wixams (new town)
• Sandy
• Biggleswade
• Shefford
• Flitwick
• Leighton Buzzard
• Houghton Regis
• Dunstable

All include additional capacity for primary care and enhanced services and many bring together two or more existing practices.

NHS Bedfordshire is committed to delivering high quality cost effective and appropriate care. It is important to ensure care delivered meets the needs of the population of Bedfordshire. Appropriate access to all care provision is essential and primary care is seen as the gateway to health services.

Patient access survey results are mainly satisfactory, although there is the occasional failure related to contingency arrangements. Each patient access survey will be formally reviewed and the strategy will be to ensure that practices are responding to the needs of patients and have appropriate contingency arrangements in place. These results will also form part of the new PBC scorecards and practice reviews. Links between access to a GP and secondary care usage will also be monitored through PBC scorecards.

As well as the patient access survey, the PCT will use other local intelligence to triangulate the results in a more local context. This will include public consultation before commissioning new premises and a PCT commissioned qualitative patient survey. In addition, this will include focus groups which will target vulnerable groups who may be experiencing difficulty in accessing primary care. The results from these will support both monitoring of current services and future action plans.

7.7. Pharmacy Provider Landscape

The NHS Constitution states:

*Patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS. NICE (the National Institute for Health and Clinical Excellence) is an independent NHS organisation producing guidance on drugs and treatments.*

Bedfordshire has 62 community pharmacies (one of which is an internet pharmacy). Two pharmacies are contracted to open at least 100 hours a week, many others also open extended hours. NHS Bedfordshire also has 24 Dispensing GP practices which provide medication for rural patients. The areas with greatest deprivation generally have good access to community pharmacies or dispensing practices.
• There are 62 pharmacies located in Bedfordshire.
• These pharmacies are located in densely populated urban areas of the region.
• The ratio of pharmacies per 100,000 population (14) is the lowest of all the East of England PCTs and is just higher than the lowest ratio (12.6) observed nationally.

Figure 14 - Pharmacies provider landscape

Getting medication is the most common interaction patients have with their pharmacy. However, many patients would benefit from further support when they visit a pharmacy, perhaps relating to an existing long term condition or to prevent ill health. We could enable this with contracting flexibility, which would give patients more choice and convenience.

The majority of NHS spend on community pharmacy is currently for dispensing prescriptions. Traditionally, pharmacies and pharmacists have been poorly utilised by the NHS to provide other services for the local population. Pharmacies are required to provide essential services under their contract and may also provide Additional and enhanced services.

Additional and enhanced services currently provided by community pharmacies in NHS Bedfordshire are:

• Medication usage reviews.
• Needle exchange.
• Supervised methadone consumption.
• Provision of emergency hormonal contraception (EHC).
• Smoking cessation and other health improvement advice.
• Vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

Community pharmacy needs to be utilised more effectively to achieve the strategic health objectives of NHS Bedfordshire. To stimulate an innovative market, community pharmacy need to be aware of NHS Bedfordshire’s health commissioning needs and fully engage with the commissioning process. Commissioners too need to be aware of the strengths and potential of community pharmacy as highlighted in ‘Pharmacy in England: Building on strengths – Delivering the future’ (White Paper).
NHS Bedfordshire aims to:

- Maximise the use of generically available drugs.
- Ensure evidence based prescribing to improve health and prevent illness.
- Implement a local strategy to reduce waste medication.
- Improve use of repeat dispensing and electronic prescribing.
- Develop clear, robust, evidence based guidelines to support safe, effective and cost-effective use of medicines within all commissioned services.

### 7.8. Pharmacy Access and Choice – Market Stimulation

NHS Bedfordshire will utilise any changes to the pharmacy control of entry regulations, which might arise following the publication of the White Paper on pharmacy, to further ensure that provision of pharmacy services meets the health needs of the population, particularly in areas of greatest deprivation. Pharmacies will also be able to deliver a much wider range of healthcare services directly commissioned by NHS Bedfordshire to meet the specific local needs of the population. This will include Darzi health centres and other developments set up to meet the needs of the growing and ageing Bedfordshire population.

Community pharmacies traditionally attract a mixed client group from the local community, not just the unwell. Areas with greatest deprivation have good access to community pharmacies, many of which open extended hours. Medication is the most common healthcare intervention, which makes pharmacists the healthcare professionals that many people most see. This makes them well placed to deliver a range of additional services, particularly around health promotion.

### 7.9. Dentistry

Over half of the dental providers in NHS Bedfordshire are currently accepting new NHS patients. Since the new contract for dentists was introduced in April 2006, the number of patients seen under the NHS in the previous 24 months in NHS Bedfordshire has risen from 201,929 to 222,151 in June 2009.

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<tr>
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<tr>
<td>September 2008</td>
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<tr>
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<td>June 2009</td>
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<td>% Change since March 2006</td>
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Table 20 - Patients treated in last two years

The first year of the new dental contract saw the proportion of the population of Bedfordshire seen by an NHS dentist increase from 51% to 55%. This increase compares favourably with both national and regional figures see table below. In Luton there has been a slight drop from 53% to around 51% over the same period.
<table>
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<th>31 March 2007</th>
<th>31 March 2009</th>
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<tr>
<td></td>
<td>Adult</td>
<td>Child</td>
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Table 21 – Percentage of patients treated locally, regionally and nationally in previous 24 months, for the years ending 31 March 2006, 2007 and 2009
Source: NHS Dental Statistics for England 2006-07

These data are supported by a postal survey of patient satisfaction sent to a random sample of patients from NHS Bedfordshire by the Dental Service Division of the NHS Business and Services Authority. From a total of 289 respondents, 89% reported that they were able to get an NHS dental appointment ‘as soon as was necessary’ and 76% were ‘completely satisfied’ with the dental treatment they received.

NHS Bedfordshire operates a ‘patient portal’ which has been marketed locally and is proving effective through improved access via a single point of contact.

This increase in patient flow puts us in the ‘green’ category for Department of Health vital signs, which is measured from March 2006, but do not look as healthy with respect to the East of England monitoring, which is measured from June 2007. However, our overall increase compares well with decreases over the same period in the East of England and England as a whole.
NHS Bedfordshire commissions dental services that have an evidence-based preventative focus and are committed to adopting the *Delivering Better Oral Health* guidance. NHS Bedfordshire is reasonably well supplied with NHS dentists in comparison with the rest of the SHA and England (Figure 14).

![Population per dentist](image)

**Figure 16 - Population per dentist**
Source: The Information Centre, NHS Dental Statistics for England – 2007-2008; PCT Fact Sheet, Bedfordshire PCT.

7.10. ‘Heat’ Mapping of Geographical Dental Access

The East of England Public Health Observatory (ERPHO) was commissioned by the Strategic Health Authority to provide mapping of distance and time for dental access within each PCT. This exercise was designed to visually demonstrate locations with poor access.

The dental practices mapped are those that have contracts for a full range of NHS patients. The maps below show the geographical distribution of general dental practices in NHS Bedfordshire with the blue area depicting those areas within a certain distance (figures 17 and 18) or travelling time (figures 19 and 20) of a dentist.
There are 34,145 people in Bedfordshire more than five miles from a dentist.

There are 4,952 people in Bedfordshire more than eight miles from a dentist.
The majority of the population is within 15 minutes of a dental practice, and all except the very north of Bedfordshire are within 30 minutes.

NHS Bedfordshire has a duty to provide or secure primary dental services to the extent it considers reasonable. In the light of this and the national and East of England targets, a draft of this paper and the mapping produced by ERPHO were discussed at the Bedfordshire and Luton Oral Health Strategy and Commissioning Group on 2 September 2008. This group includes a range of dental professionals, NHS Bedfordshire representation and patient representatives. This group felt that a 12 mile distance to a dental practice would be set for those areas not already covered by the five and eight mile distances. Nevertheless, the salaried dental services do provide mobile and domiciliary services for those people who are housebound and immobile.

Overall, NHS Bedfordshire has good levels of access to primary dental services. This is evidenced within the oral health needs assessment for Bedfordshire and Luton PCTs’ working document September 2008 and from the NHS dental statistics for England and a recent postal survey patient satisfaction survey.

The Bedfordshire JSNA identifies specific groups where there is concern. These include homeless, looked after children, prisoner and young offenders, people with mental illness, black and minority ethnic groups, travellers and those with disabilities.

7.11 Community Health Services

It was decided by the PCT board in May 2008 to pursue a managed contestability approach to divesting itself of its provider arm. This is part of the national agenda to review and develop a way forward to deliver the separation of commissioning and provision of services.

The provider services operate as an arms length trading organisation (ALTO) under the name of Bedfordshire Community Health Services. The services have been clustered / grouped in five key areas:

1. Treatment and Procedures Out of Hospital
2. Children and Family Services
3. Long Term Conditions
4. Rehabilitation and Enablement
5. End of Life.

The Treatment and Procedures Out of Hospital group comprises a wide ranging groups of services which could be managed and delivered independent of the other services. This is the first tranche of services to be market tested.

Managed contestability is a means to delivering a number of high level benefits:

1. Better clinical and patient experience outcomes for patients
2. Better integrated pathways and services for patients in the community that reduce reliance on hospital services
3. A wider range of high quality, innovative and responsive community providers and services
4. Improved value for money – better quality, lower costs
5. Improved productivity, releasing money for reinvesting in services
6. NHS Bedfordshire focusing on becoming a world class commissioner, not a provider of care
7. Increased choice for referrers and patients through competition
8. Improved development and innovation opportunities for staff.

Pathway Redesign

As part of pathway redesign, we have commissioned a series of service reviews to ensure that services meet the needs of the Bedfordshire population and that the services have the skill set and capacity to deliver appropriate, high quality care in a timely way (maximum referral to treatment of 18 weeks for planned services) as part of an overall patient pathway. The reviews will measure quality, accessibility, cost effectiveness and priority. Wherever possible, they will be undertaken with the local authority.

NHS Bedfordshire’s approach to pathway redesign is underpinned by the commissioning cycle within the World Class Commissioning framework. This includes comprehensive needs assessment, robust prioritisation, effective procurement processes and robust monitoring and evaluation.

Future Position of Community Health Services

The Board of NHS Bedfordshire has decided to pursue service and pathway integration with other providers as the preferred option for the next steps for the ALTO. This will result in NHS Bedfordshire ceasing to be a provider of services in 2010.

This will help to improve the responsiveness of community services, whilst ensuring choice, competition and contestability.

Our strategy sets out ambitious targets for investment into primary and community services. The range of high quality and safe community services that we commission will be central to the success of this strategy.

As a world class commissioner, we will specify the range of services required to support care closer to home in the community. We will actively use the market to secure these services.

7.12 Independent Care Providers (Nursing Homes)

There are 25 independent nursing homes in Bedfordshire, which NHS Bedfordshire uses directly and indirectly to commission care for the population of Bedfordshire.
NHS Bedfordshire has developed a contract in parallel with the local authority for directly commissioned care, in order to drive up the quality of care provided. The independent sector has a key role in the delivery of residential continuing healthcare and continuing care. NHS Bedfordshire will continue to work in partnership to ensure the maintenance of safe and effective care. NHS Bedfordshire will support programmes such as infection control training, safeguarding of vulnerable adults (SOVA) and tissue viability.

This partnership will also investigate their future role in the shift from secondary to primary care.

**Domiciliary Care**

NHS Bedfordshire’s continuing healthcare department is developing a domiciliary care contract for NHS continuing healthcare patients who are the responsibility of NHS Bedfordshire. This contract will ensure that all providers are at the standards required to provide care to this patient group. However, it will also enable the department to monitor and performance manage the individual providers.

**7.13 Mental Health Services**

There are three main providers of mental health services to Bedfordshire. The largest contract is with Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BLPT). The other providers are Cambridgeshire and Peterborough Foundation Trust and South London and Maudsley NHS Foundation Trust (SLaM)

BLPT provides the majority of mental health and learning disability services to Bedfordshire residents. NHS Bedfordshire has been working closely with the Board of BLPT to improve patient experience and outcomes. NHS Bedfordshire sought a foundation trust partner to support BLPT in improving the patient experience and journey. The tendering process has resulted in South Essex Partnership NHS Foundation Trust (SEPT) being chosen to take over the running of the trust in 2010. NHS Bedfordshire is working closely with them to improve services, patient experiences and outcomes.

Unlike acute and specialist provision, there is a lack of mental health providers locally, and secure facilities are more limited. This has the potential to reduce the benefits related to competition and impacts on choice. NHS Bedfordshire would like to increase its commissioning arrangements with other providers, including the voluntary sector, to enhance patient experience and choice.

NHS Bedfordshire purchases a number of placements from private providers, particularly for people with learning disabilities and for those requiring elderly mentally ill nursing and residential care.

NHS Bedfordshire will market test the Improving Access to Psychological Therapies service, following the initial pilot period across a range of providers, including the third sector. This will enhance NHS Bedfordshire’s primary care mental health model. We
are also considering market testing for specialist learning disability provision and future dementia care.

7.14 Developing the Local Market

Over the next five years, starting in 2009/10, the delivery of NHS Bedfordshire’s strategic objectives will require more services to be delivered differently if the challenges of population change and healthcare needs are to be met. Effective and well managed market development is recognised as a powerful tool to stimulate the entry of new and different providers as well as stimulating innovation across the health system.

To ensure that these benefits can be fully realised locally, NHS Bedfordshire will be adopting a five year strategic plan to identify areas where a market development approach can be used to realise greatest potential benefits.

Local Market Development Activities

Progress to Date

During the past year NHS Bedfordshire has undertaken the following activities in relation to market development:

- We have developed a market intelligence database containing details of the services offered by more than 1,000 providers
- We delivered a provider engagement day, which more than 200 providers attended. The day outlined the strategic vision for market management in Bedfordshire and provided attendees with the opportunity to learn more about specific areas where commercial activity is planned for the coming year
- The provider event also marked the launch of NHS Bedfordshire’s provider list. The list provides suppliers with the opportunity to qualify as a provider of healthcare services for NHS Bedfordshire, enabling them to directly access future tenders without the need for repeat qualifications
- We have started to segment the local healthcare market into categories which can be used in the market analysis stages of procurement projects and to support the sourcing of suppliers for future contracts
- We have developed a sub website to www.bedfordshire.nhs.uk for details of tender opportunities and to provide a means of engaging with providers.

Planned Market Development Activities

- To enhance the management of market development activity by:
- To complete a comprehensive local healthcare market analysis to support the commissioning process
- To achieve Level 3 of World Class Commissioning Competency Seven
• To implement an electronic contract management and procurement portal to improve the management of existing and emerging markets
• To deliver the successful procurement projects to the value of over £40m
• To support the transition of Bedfordshire Community Healthcare Services to new providers, with appropriate market analysis information to enable effective procurement of future community healthcare services.

8 Impact of Challenges on our Future Finances

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire’s strategy will require:

• Increased efficiency savings.
• Rigorous fair and transparent prioritisation.
• Selling assets which are not fit for purpose and reinvesting the proceeds in appropriate, modern facilities.
• Spend on acute and specialist services currently consumes circa 45% (£229m) of our income, whilst spend on out of hospital services consumes 55% (£276m). This balance will need to change.
• NHS Bedfordshire’s income will rise from a current £505.6m in 2008/09 to £644.2m in 2013/14. Our investment plans demonstrate how this will be spent.

8.1. Current Financial Situation

NHS Bedfordshire ended 2007/08 with a small revenue surplus of £133,000, after successfully implementing a financial ‘turnaround’ plan in excess of £35m. The trust, therefore, moved into 2008/09 in overall financial balance and with no historic deficit.

A balanced financial plan for 2008/09 totalling £505m was approved by the trust board in May 2008. This represented a set of realistic but challenging budgets and included a small uncommitted contingency sum of £3.2m (0.6%).

The lessons learned from last year’s turnaround process have been incorporated into updated systems and processes across the organisation. A programme of re-skilling all budget managers and supporting finance staff has been implemented and ongoing financial monitoring and forecasting procedures have been strengthened.

NHS Bedfordshire remains on target to achieve a break-even out turn for 2008/09. Under-spending evident during the first half of the current financial year will not be
maintained at the same level in the coming months as the recruitment process continues to fill staff vacancies frozen during the financial recovery of last year.

Financial pressures remain evident on acute activity levels/costs, and the implementation of NICE guidance will increase other costs during the second half of this year.

Expenditure linked to the restructuring of ‘corporate’ NHS Bedfordshire into a World Class Commissioning organisation will also increase towards the end of 2008/09.

All of these costs, together with those relating to other financial pressures that may become evident, will be contained within the existing overall budget provisions to enable statutory targets to be met for the year end.

The full year implications of these pressures and initiatives will be built into the financial plans for 2009/10 and future years.

8.2. Future Position

Revenue resource allocations for 2009/10 and 2010/11 have now been announced by the Department of Health, which confirms an increase in resources for NHS Bedfordshire of 11.9% over the two year period.

The baseline allocation for 2009/10 is confirmed as £552.0 million and for 2010/11 it is £585.4 million. These details now form the basis of the financial plan for the early years of the strategy.

The total for 2010/11 does, however, still leave the resources allocated to NHS Bedfordshire some 3.5% below the Department of Health calculation of fair share allocation.

For 2011/12 and beyond, we have made resource assumptions, based on best available current information. Given the continuing uncertain national economic situation, we have built a series of ‘realistic’ and ‘worst’ case scenarios in our plans.

We have made the following assumptions:

- Future health inflation to commissioners reflects a 3% productivity gain. The net average increase is 2.5% in acute service prices for the first two years, including CQVI, reducing to 1% for the remaining three years. The same assumption has been made for non tariff based costs at this stage.

- Prescribing costs assume a year on year 6% uplift.

- No additional central funding will be made available to cover predicted population growth during the period, and that costs associated with this will need to be contained within funding parameters noted below.

- The return of deposits held by NHS East of England have been factored into the resource totals over the period, with a residual figure of £3m assumed as still being retained at the end of 2013/14.
### Realistic Case Financial Projections

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#### Total Resource Expenditure inc Cost Pressures, Inflation & Population Growth and Initiatives

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**Table 22 - Realistic case financial projection**

The ‘realistic’ case produces a break even position across the strategic period, whilst ensuring that a reasonable level of contingency funds is maintained.

### Worst Case Financial Projections

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#### Total Resource Expenditure inc Cost Pressures, Inflation & Population Growth and Initiatives

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<td>-15,218</td>
<td>-20,177</td>
</tr>
</tbody>
</table>

**Table 23 Worst case financial projection**
The ‘worst case’ resource assumptions would mean a reduced level of new growth money equivalent to £28m per annum by 2013/14. This would clearly have a significant impact on investment plans for 2011/12 and beyond and would mean that a number of the planned initiatives for that period would need to be re-phased or deferred.

8.3. Allocation of Additional Resources

The bridge diagram below shows how the additional funding of £139m between 2008/09 and 2013/14 will be spent.

![Bridge diagram of additional spent between 2008/09 and 2013/14](Figure 21 - Bridge diagram of additional spent between 2008/09 and 2013/14)

Specifically, we must compare the position now with the position in 2013/14:

- The population of Bedfordshire is expected to increase as people live longer. This will cost an additional £6m.
- Bedfordshire is also an area targeted for new housing developments and its population is expected to increase by 5.6% by 2013/14. It is estimated that the additional cost of health service provision related to population changes will be £32m.
- We plan to invest more money (£4m) into prevention.
- This is likely to be supported by an increase in prescribing and we estimate that this will cost an additional £29m.
• We also plan to increase the capacity within primary and community care and an additional £46m funding has been allocated to this strategic priority.

• This will be partly financed by productivity savings of £19m in hospital referrals and emergency admissions.

• We intend to focus resources in acute hospitals on those that need it. Although funding for this sector will increase over the period by £24m, the allocation will be less than inflation and therefore, funding will be reduced in real terms.

  • Of this increase in income of circa £139 million, 16% (£23m) will be spent on acute and specialist services. The remaining 84% (£116m) will be spent on out of hospital services.

  • This represents a significant shift in the focus of our spend by 2013/14. The balance of spend shifts to 39% (£252m) on acute and specialist services and 61% (£392m) on out of hospital services.

  • The delivery of our strategy will require changes to the role and ways of working of existing hospitals.

8.4. Strategic Themes

Detailed implementation plans in Appendix A of this document set out the changes required across the life pathway from birth to life:

• Staying healthy
• Mental health (including drug users) and learning disability
• Maternity and new born
• Children’s services

• Planned care, including dental
• Acute care

• Long term conditions
• End of life care
The funding associated with these themes are detailed below

<table>
<thead>
<tr>
<th>Pathway £’000</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying healthy</td>
<td>333</td>
<td>609</td>
<td>1,423</td>
<td>1,437</td>
<td>1,452</td>
</tr>
<tr>
<td>Mental health (including drug users) and learning disability</td>
<td>380</td>
<td>390</td>
<td>393</td>
<td>397</td>
<td>401</td>
</tr>
<tr>
<td>Maternity and new born</td>
<td>693</td>
<td>710</td>
<td>717</td>
<td>725</td>
<td>732</td>
</tr>
<tr>
<td>Children’s services</td>
<td>145</td>
<td>1,675</td>
<td>2,620</td>
<td>2,646</td>
<td>2,673</td>
</tr>
<tr>
<td>Planned care, including dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity Gain</td>
<td>(1,310)</td>
<td>(2,620)</td>
<td>(2,646)</td>
<td>(2,673)</td>
<td>(2,699)</td>
</tr>
<tr>
<td>Service Redesign (savings)</td>
<td>(4,721)</td>
<td>(7,161)</td>
<td>(7,233)</td>
<td>(7,305)</td>
<td>(7,378)</td>
</tr>
<tr>
<td>Service Redesign (costs)</td>
<td>5,000</td>
<td>10,000</td>
<td>10,100</td>
<td>10,201</td>
<td>10,303</td>
</tr>
<tr>
<td>Acute care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity Gain</td>
<td>(3,522)</td>
<td>(3,610)</td>
<td>(3,646)</td>
<td>(3,683)</td>
<td>(3,719)</td>
</tr>
<tr>
<td>Service Redesign (savings)</td>
<td>0</td>
<td>(5,922)</td>
<td>(4,752)</td>
<td>(4,800)</td>
<td>(4,848)</td>
</tr>
<tr>
<td>Service Redesign (costs)</td>
<td>1,857</td>
<td>9,000</td>
<td>9,090</td>
<td>9,181</td>
<td>9,273</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>2,000</td>
<td>3,000</td>
<td>3,030</td>
<td>3,060</td>
<td>3,091</td>
</tr>
<tr>
<td>End of life care</td>
<td>1,004</td>
<td>4,000</td>
<td>4,040</td>
<td>4,080</td>
<td>4,121</td>
</tr>
<tr>
<td>Total</td>
<td>4,859</td>
<td>10,071</td>
<td>13,136</td>
<td>13,266</td>
<td>13,402</td>
</tr>
</tbody>
</table>

Table 24 - Funding across 8 strategic priorities

Prioritisation of Investment

NHS Bedfordshire’s strategy is ambitious. Resources, in terms of money, change management capacity and infrastructure are limited. Resources are likely to be further stretched as our population grows. Delivering the strategy will require us to focus efforts where they have the greatest impact. The operational plan sets out what actions we will take to do this each year.

Over the life of the strategy, we will increasingly require cash releasing savings and new growth money to support the introduction of new initiatives which cannot be delivered through redesign of existing pathways and use of existing budgets. A high priority for NHS Bedfordshire, therefore, is to drive efficiency.

It is recognised that focusing hospital services on those that need it and maximising the impact of local out of hospital services will not only improve patient experience but also drive the effective use of resources. The pace of change will be driven by our
ability to identify efficiency savings in more traditional ways of working that we can reinvest into doing things in new, more effective ways.

We will keep this under continual review and closely monitor progress in achieving cash releasing efficiency savings.

We have put a scheme of delegation in place with Practice Based Commissioners to facilitate innovation and the speedy introduction of change in line with this strategic theme. Building on this, we are developing a system to support PBCs to take a similar approach with each of the 23 programme budgets: reviewing care within the programme budgets in line with NHS Bedfordshire’s strategy to identify efficiencies.

Reducing Health inequalities will also require a move from funding based on history to funding informed by an assessment of need. In order to drive the reduction of health inequalities, future Practice Based Commissioning funding will be informed by an estimate of need and population changes. It is expected that PBC gaining resources not only invest in treatment to respond to immediate need but also in prevention and work to reduce health inequalities.

In order to inform future years of the operational plan, we will also review initiatives through a prioritisation panel which considers:

- Fit with NHS Bedfordshire’s strategy
- Health outcome
- Clinical effectiveness
- Cost effectiveness
- Equity
- Access
- Patient choice
- Affordability
- Needs of the community
- Quality
- Policy drivers
- Exceptional need

This will further drive the efficient use of resources. Our operational plan sets out each year’s implementation plans.

As the panel develops, it will review not only new interventions but interventions within existing programme budgets to assess whether the current balance of funding across programme budgets is appropriate to meet our goals.

For further details, also see Appendix F, Prioritisation Policy.

8.5. Reshaping the Landscape through Programme Budgets

Programme budgets are used by the NHS to produce clear information as to where funding is spent according to clinical areas. From 2009/10, NHS Bedfordshire will use programme budgeting to underpin the implementation of the organisation’s five year strategic plan in addition to the development of local healthcare markets.

Our current resource limit is attributed across 23 programme budgets, as set out in the table below. We will assess current spend across providers and recommission care against evidence based care pathways. This will mean changing what we spend across the 23 programme budget areas.
Our commitments to improve on our data submissions have resulted in a significant improvement across all Programme Budget codes and in particular a reduction in the amount of spend recorded under ‘Other’. We have reduced the 2007/08 amount by 15.6% and the total spend is now only 18.6% of the total PCT spend. However, 12.8% of this is our GMS/PMS spend (the highest within the East Of England patch). The GMS/PMS spend has to be shown under category 23a (a sub-section of ‘Other’) as per Department of Health guidelines so, in effect, our genuine ‘Other’ spend is only 5.8% (£30m) compared to 10.1% (£49m) last year.

This has largely been achieved by greater communication/personal visits to our larger trusts, particularly Bedford Hospital and highlighting the importance of the data being analysed as fully as possible. This has resulted in the trusts providing superior data submissions via Unify and hence a more accurate submission by us.

<table>
<thead>
<tr>
<th>Programme Budget Analysis</th>
<th>2007/08 Data £'000</th>
<th>% of PCT Spend</th>
<th>2008/09 Data £'000</th>
<th>% of PCT Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious Diseases</td>
<td>6,093</td>
<td>1.25%</td>
<td>7,349</td>
<td>1.39%</td>
</tr>
<tr>
<td>Cancers and Tumours</td>
<td>27,634</td>
<td>5.68%</td>
<td>31,610</td>
<td>5.96%</td>
</tr>
<tr>
<td>Blood Disorders</td>
<td>4,668</td>
<td>0.96%</td>
<td>5,388</td>
<td>1.02%</td>
</tr>
<tr>
<td>Endocrine, Nutritional and Metabolic</td>
<td>14,554</td>
<td>2.99%</td>
<td>16,729</td>
<td>3.15%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>49,221</td>
<td>10.11%</td>
<td>59,330</td>
<td>11.19%</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>24,484</td>
<td>5.03%</td>
<td>36,215</td>
<td>6.83%</td>
</tr>
<tr>
<td>Neurological</td>
<td>14,923</td>
<td>3.06%</td>
<td>21,225</td>
<td>4.00%</td>
</tr>
<tr>
<td>Eye / Vision</td>
<td>11,682</td>
<td>2.40%</td>
<td>12,660</td>
<td>2.39%</td>
</tr>
<tr>
<td>Hearing</td>
<td>2,638</td>
<td>0.54%</td>
<td>2,706</td>
<td>0.51%</td>
</tr>
<tr>
<td>Circulation (CHD)</td>
<td>39,770</td>
<td>8.17%</td>
<td>42,759</td>
<td>8.06%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>19,638</td>
<td>4.03%</td>
<td>25,299</td>
<td>4.77%</td>
</tr>
<tr>
<td>Dental</td>
<td>25,677</td>
<td>5.27%</td>
<td>25,679</td>
<td>4.84%</td>
</tr>
<tr>
<td>Gastro-Intestinal</td>
<td>24,837</td>
<td>5.10%</td>
<td>28,515</td>
<td>5.38%</td>
</tr>
<tr>
<td>Skin</td>
<td>9,604</td>
<td>1.97%</td>
<td>9,925</td>
<td>1.87%</td>
</tr>
<tr>
<td>Musculoskeletal System</td>
<td>23,096</td>
<td>4.74%</td>
<td>22,700</td>
<td>4.28%</td>
</tr>
<tr>
<td>Trauma and Injuries (including burns)</td>
<td>12,869</td>
<td>2.64%</td>
<td>16,782</td>
<td>3.16%</td>
</tr>
<tr>
<td>Genito Urinary System</td>
<td>20,232</td>
<td>4.15%</td>
<td>21,682</td>
<td>4.09%</td>
</tr>
<tr>
<td>Maternity and Reproductive Health</td>
<td>19,677</td>
<td>4.04%</td>
<td>20,831</td>
<td>3.93%</td>
</tr>
<tr>
<td>Neonates</td>
<td>5,282</td>
<td>1.08%</td>
<td>6,073</td>
<td>1.15%</td>
</tr>
<tr>
<td>Adverse Effects of Poisoning</td>
<td>4,797</td>
<td>0.99%</td>
<td>6,101</td>
<td>1.15%</td>
</tr>
<tr>
<td>Healthy Individuals</td>
<td>7,367</td>
<td>1.51%</td>
<td>10,005</td>
<td>1.89%</td>
</tr>
<tr>
<td>Social Care Needs</td>
<td>1,373</td>
<td>0.28%</td>
<td>2,126</td>
<td>0.40%</td>
</tr>
<tr>
<td>Other</td>
<td>116,828</td>
<td>23.99%</td>
<td>98,657</td>
<td>18.60%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>486,945</td>
<td>100.00%</td>
<td>530,345</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Table 25 - Spend across 23 programme budgets

Shifting care closer to home will mean redefining the role of acute hospitals. Capacity freed up within the secondary care sector provides an opportunity for secondary care providers locally to refocus their skill and competencies in order to provide some additional services closer to home.

8.6. Capital Investment Plan

A summary of the presently proposed capital investment plan is noted below.

The figures reflect the ongoing block capital requirements for the replacement of IT and other equipment assets. They also include estimated sums for the future
investment in the NHS Bedfordshire owned estate from 2009/10 onwards. These
details will be reviewed and updated on completion of the PCT’s estates strategy.

<table>
<thead>
<tr>
<th></th>
<th>2009/10 £'000</th>
<th>2010/11 £'000</th>
<th>2011/12 £'000</th>
<th>2012/13 £'000</th>
<th>2013/14 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backlog maintenance and premises upgrades</td>
<td>740</td>
<td>760</td>
<td>780</td>
<td>800</td>
<td>820</td>
</tr>
<tr>
<td>IT/other equipment replacements</td>
<td>740</td>
<td>760</td>
<td>780</td>
<td>800</td>
<td>820</td>
</tr>
<tr>
<td>TOTAL BLOCK CAPITAL</td>
<td>1480</td>
<td>1520</td>
<td>1560</td>
<td>1600</td>
<td>1640</td>
</tr>
<tr>
<td>Completion of 08/09 projects (including Bedford Health Village schemes)</td>
<td>820</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shires House development</td>
<td>300</td>
<td>5000</td>
<td>1000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New primary care facilities</td>
<td>2120</td>
<td>800</td>
<td>5000</td>
<td>5000</td>
<td>2000</td>
</tr>
<tr>
<td>Grants to third parties</td>
<td>2100</td>
<td>400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land sales</td>
<td>(350)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 26 - Block capital projection

Funding sources for these developments will be a combination of Department of Health capital resource allocation and funding secured via LIFT Co.

9 Delivering our Strategy

Three strategic priorities will drive our implementation plans:

1. Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).

2. Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean:
   - Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it.
   - Ensuring shorter waiting times for treatment
   - Respecting the wishes of patients about their care from birth to the end of their life.

3. Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.
9.1 Overview

Detailed implementation plans in Appendix A of this document set out the changes required across the eight areas:

- Staying healthy
- Mental health (including drug users) and learning disabilities
- Maternity and new born
- Children’s services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

The three strategic priorities set out above emerge throughout all eight implementation plans.

9.2 Links to Underpinning Plans

The table below illustrates how the initiatives link to our goals and world class commissioning metrics.

<table>
<thead>
<tr>
<th>Goals</th>
<th>Better patient experience</th>
<th>Access to quality, safe clinically and cost effective local services.</th>
<th>Improving Health</th>
<th>Reducing Unfairness</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCC Metrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiatives</td>
<td>Patient experience</td>
<td>GP access</td>
<td>Access to dental care</td>
<td>Safety</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental Health, Including Drug Users</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maternity and New Born</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Planned Care, including Dental</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Acute Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 27 - Initiatives linked to goals
## Pledges

**Towards the best, together**

- **Delivering A Better Experience For Patients**
  - We will deliver year on year improvements in patient experience.
  - We will extend access guarantees to more of our services.
  - We will ensure that GP practices improve access and become more responsive to the needs of all patients.
  - We will ensure that NHS primary dental services are available to all who need them.
  - We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke, cancer and dementia.
  - We will make our health service the safest in England.
  - We will improve the lives of those with long term conditions.
  - Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT.
  - We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us.

- **Improving Peoples Health**
  - We will deliver year on year improvements in patient experience.
  - We will extend access guarantees to more of our services.
  - We will ensure that GP practices improve access and become more responsive to the needs of all patients.
  - We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke, cancer and dementia.
  - We will make our health service the safest in England.
  - We will improve the lives of those with long term conditions.
  - Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT.
  - We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us.

- **Reducing Unfairness In Health**
  - We will deliver year on year improvements in patient experience.
  - We will extend access guarantees to more of our services.
  - We will ensure that GP practices improve access and become more responsive to the needs of all patients.
  - We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke, cancer and dementia.
  - We will make our health service the safest in England.
  - We will improve the lives of those with long term conditions.
  - Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT.
  - We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us.

### Initiatives

- **Staying Healthy**
  - Increase the life expectancy of males
  - Increase the life expectancy of females
  - Reduce health inequalities between the worst and best 20% of our communities
  - Improve the lives of those with long term illness
  - Increase the number of smoking quitters
  - Halve the rise in obese children and the seek to reduce it
  - Deliver year on year improvements in patient experience
  - Ensure GP practices improve access and become more responsible to the needs of all patients
  - Ensure NHS Primary Dental Services are available to all who need them
  - Reduce the C. Difficile infection rates
  - Increase the percentage of drug users in effective treatment

- **Mental Health Including Drug Users**
- **Maternity and New Born**
- **Children’s Services**
- **Planned Care Including Dental**
- **Acute Care**
- **Long Term Conditions**
- **End of Life Care**

### Table 28 - Initiatives linked to pledges

<table>
<thead>
<tr>
<th>Success Measure</th>
<th>Staying Healthy</th>
<th>Mental Health Including Drug Users</th>
<th>Maternity and New Born</th>
<th>Children’s Services</th>
<th>Planned Care Including Dental</th>
<th>Acute Care</th>
<th>Long Term Conditions</th>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the life expectancy of males</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Increase the life expectancy of females</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce health inequalities between the worst and best 20% of our communities</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve the lives of those with long term illness</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of smoking quitters</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Halve the rise in obese children and the seek to reduce it</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver year on year improvements in patient experience</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure GP practices improve access and become more responsible to the needs of all patients</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure NHS Primary Dental Services are available to all who need them</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Reduce the C. Difficile infection rates</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Increase the percentage of drug users in effective treatment</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Table 29 – Projects under way mapped against success measures

<table>
<thead>
<tr>
<th>Success Measure</th>
<th>Staying Healthy</th>
<th>Mental Health Including Drug Users</th>
<th>Maternity and New Born</th>
<th>Children’s Services</th>
<th>Planned Care Including Dental</th>
<th>Acute Care</th>
<th>Long Term Conditions</th>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the life expectancy of males</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Increase the life expectancy of females</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>Reduce health inequalities between the worst and best 20% of our communities</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Improve the lives of those with long term illness</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Increase the number of smoking quitters</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Halve the rise in obese children and the seek to reduce it</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Deliver year on year improvements in patient experience</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Ensure GP practices improve access and become more responsible to the needs of all patients</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ensure NHS Primary Dental Services are available to all who need them</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Reduce the C. Difficile infection rates</td>
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<tr>
<td>Increase the percentage of drug users in effective treatment</td>
<td>X</td>
<td></td>
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</tbody>
</table>
9.3 **Strategic Initiative Summary Plans**

The next section provides a summary of what the strategy will deliver. Appendix A contains detailed plans as to how this will be achieved.

9.3.1 **Staying Healthy**

A key aspiration for Bedfordshire is to increase life expectancy for its residents. To do this we must tackle the main causes of premature death: cancer, CHD/stroke; accidents; suicide and liver disease through:

- A life long prevention pathway
- Promoting wellbeing
- Reducing unfairness
- Health partnerships.

**We will:**

- Implement NHS Health Checks across Bedfordshire
- Tackle childhood obesity through the implementation of EPODE type prevention approaches with schools and MEND obesity management programmes
- Reduce the number of people who smoke
- Develop a joint alcohol strategy with the local authority to reduce alcohol related harm
- Develop integrated and personalised approaches to delivering lifestyle support services
- Reduce inequalities in health through initiatives such as: targeting smoking cessation work on the 20% most deprived wards and GP practice populations; promoting the uptake of CVD prevention in most deprived wards; carrying out a health equity audit of breast and cervical screening uptake; carrying out a baseline audit of access to antenatal care to identify areas of late booking; and providing teenage pregnancy programmes and projects
- Continue to work very closely with the local authorities to identify baselines, targets and effective interventions for current and future Local Area Agreement achievement. This will be underpinned by the updated Joint Strategic Needs Assessment
- Develop Staying Healthy in the Workplace and roll this out across the county.

9.3.2 **Mental Health and Learning Disabilities**

Bedfordshire’s joint mental health strategy aims to improve the outcomes and life prospects of people with mental health problems. This means that services will be based on evidence, are acceptable and accessible to local people, are relevant to the
needs of the local population and delivered in a fair and equitable way. The focus of care will move away from acute settings to prevention and primary care.

We will:

- Develop a new approach to the early identification of mental health and develop locally based health promotion initiatives based on the health promotion strategy 2010-2014
- Implement the stepped care model for depression, anxiety and common mental health problems, ensuring these are delivered through the implementation of IAPT
- Move away from institutional to personalised care focusing on recovery, enhanced social inclusion and utilising personalised budgets in conjunction with the local authority transforming social care agenda in both mental health and learning disability services
- Earlier identification and treatment of dementia, developing more community focused services and addressing individual needs throughout the pathway, based on a locally developed and agreed dementia strategy and implementation plan
- Improve therapeutic quality of acute inpatient care through the reprovision of currently commissioned services. This will reduce inpatient provision while supporting the development of services based in primary care. To support this, we will undertake capacity planning work within both inpatient and community mental health team provision
- Improve the integration of care co-ordination and care management in mental health services for older people, ensuring these are implemented and imbedded in organic and functional service delivery pathways
- Deliver the ‘Valuing People’ objectives for people with a learning disability based on four key principles of rights, independence, choice, and inclusion
- Ensure services effectively meet the mental health needs of people with a learning disability through the implementation of ‘Valuing Health for All’
- We will ensure that all vital sign targets and trajectories are monitored through robust performance, quality and contracting meetings (vital sign targets can be found in Performance Report (Appendix E)
- We will undertake service review and redesign of specialist mental health services that includes care pathways for eating disorders, personality disorders, rehabilitation services and continuing health care
- We will implement the fundamental principles stated within the national carers strategy and this will be delivered through the development of a joint Bedfordshire strategy with clearly commissioned services.

The current programme budget for mental health and learning disabilities can support this agenda through the shift from acute hospital based care to primary and community based services.
Drugs Treatment

Drug misuse is an issue which has an impact on our local communities in many different ways. This agenda is managed through a multi agency Drug and Alcohol Partnership Board whose main focus is to implement consistent, evidence based interventions that reduce levels of drug use in the county, improve detection and arrest rates and increase the numbers of drug users entering successful treatment programmes.

We will:

• Enable specific crime related interventions to include: closure of crack houses and cannabis factories; seizure of assets of convicted dealers; and disrupting drug markets
• Develop and implement IDTS at HMP Bedford
• Target drug misusing offenders through drug testing on arrest throughout the county
• Develop consistent drug services across the county, targeted in areas of greatest need
• Improve the local treatment system and deliver better outcomes for individuals
• Support local campaigns such as RAT on a RAT
• Continue close multi agency working.

There is a need to invest in this agenda up to an additional £1m a year.

9.3.3 Maternity and New Born

NHS Bedfordshire’s maternity strategy aims to improve local maternity services for all women and families, in particular:

• To reduce health inequalities by reconfiguring antenatal and postnatal services
• To offer more choice to women about how they access antenatal and postnatal care
• To improve the quality of care women receive when they have their baby, including ensuring women receive one to one midwifery care in established labour.

We will:

• Ensure broader access to antenatal and postnatal care by providing services through children’s centres and providing services at a time convenient to women and their families
• Improve pathways and partnership working with support services such as smoking cessation to reduce the number of women smoking in pregnancy
• Improve support to women who experience pre-natal mental health problems
• Target resources to areas of greatest health inequalities – low breastfeeding rates, low birth rates, areas with high levels of teenage pregnancy
• Develop local midwifery led birthing units co-located with maternity units at Bedford Hospital and at the Luton and Dunstable Hospital and ensure this choice is offered to all women
• Maintain level 1 cots at Bedford Hospital and level 3 at the Luton and Dunstable Hospital
• Promote normality of birth and ensure all women have a choice of where to give birth, based on the assessment of mother and baby.

The current programme budget for maternity can support this agenda.

**9.3.4 Children’s Services**

Taking a pathway approach to the provision of services for children across Bedfordshire will ensure that children’s health needs are considered at all stages and across all agencies, and that seamless provision delivers year on year improvements in the health of Bedfordshire’s children. We have begun to work with the unitary authorities to look at the opportunities for the integration of commissioning and provision of children’s services.

**We will:**

• Continue to develop the Healthy Child programme to develop world class universal services to improve the health outcomes for children from an early age. There will be a particular focus on links with GPs and children's centres addressing childhood obesity, sexual health, teenage pregnancy, drug and alcohol abuse and smoking reduction
• Support and develop the Healthy Schools programme
• Continue to work with local authorities to support the development of 32 multi agency children’s centres across Bedfordshire
• Continue to improve the access to specialist services for assessment and treatment for children, particularly therapy services
• Focus additional support on vulnerable groups of children and people, including looked after children
• In partnership with local authority colleagues, continue to develop the range and quality of local child and adolescent mental health services
• Ensure the needs of adolescents are properly addressed as close to home as possible
• Continue to implement our plans to significantly improve the lives of disabled children in the county
• Develop community based children’s assessment services and review current acute inpatient services across the county.
9.3.5 Planned Care, including Dental

The aim is to deliver convenient, planned care closer to home, away from acute hospitals working closely with primary care. There is a strong focus on localisation, choice, co-ordination across organisational boundaries and a split from acute services.

We will:

- Ensure a waiting time from referral to treatment of less than 18 weeks, other than clinical exceptions and patient choice
- Ensure equitable access to a full range of high quality primary care services provided by general practice, dentists, optometrists and pharmacists
- Invest in the infrastructure of primary care to support this transfer to high quality, locally based care
- Develop direct access to diagnostics and availability of results prior to consultant appointment, including the development of some community based diagnostics
- Provide complex treatments in specialist centres to improve patient safety and clinical outcomes. This will involve some Bedfordshire patients being treated out of county
- Increase the number of minor and routine procedures undertaken in primary care to. 40% of OPDs in the community; 60% of minor planned surgery and 20% of non complex planned medicine
- Roll out choose and book to non consultant led services and ensure choice of planned services is available
- Ensure effective rehabilitation and community based services are in place to minimise hospital stays and maximise recovery.

The current budget for planned care can support this agenda and release about £1m to support investment in other work streams through the shift from acute hospital based care to primary and community based services.

Dental Services

Our aim is that everyone served by NHS Bedfordshire will be able to access an NHS dentist if they wish to and that the appropriate age group get timely 18 week compliant access to orthodontic treatment.

We will:

- Offer every resident in Bedfordshire access to a NHS dentist
- Increase the units of dental activity (UDAs) commissioned from general dental practitioners
• Ensure compliance with the contract by all existing providers to deliver maximum yield from commissioned services
• Increase case starts for orthodontics
• Address long waiting times for treatment
• Promote waiting list management
• Offer extended hours
• Increase the number of minor and routine dental procedures undertaken in primary care by transferring them from hospital to high quality community settings.

9.3.6 Acute Care

The aim is to put in place joined up, co-ordinated, responsive and patient focused services for people that require urgent or emergency care. The focus is on community based alternatives to hospital care whilst recognising that specialising in some areas of acute care will save lives.

We will:

• Ensure patients have equitable access, quality of assessment and safe treatment consistent with their condition when requiring urgent care. This should be focused in primary care
• Establish a memorable number for the population to call for health information and self care advice, onward signposting and referral and booking into planned and unplanned care. This is likely to be a regional initiative
• Ensure wider, easier emergency access to emergency contraception, GP services and pharmacy
• Extend the single point of access concept as a responsive route for clinicians and patients into 24/7 rapid response community services to facilitate people staying at home
• Ensure faster and more responsive ambulance services that can offer alternatives to admission for patients
• Establish primary care led urgent care centres 24/7 at A&E at Bedford Hospital and at the Luton and Dunstable Hospital
• Ensure acute hospital care is organised to support rapid assessment, diagnosis and discharge back into primary care, whenever possible
• Centralise services where additional lives will be saved and better clinical outcomes achieved, this includes 24/7 stroke centres at both Bedford and Luton hospitals
• Develop a pathway for Bedfordshire patients to specialist heart attack centres at Papworth and Harefield hospitals, with local services for thrombolysis, rehabilitation and follow up
• Ensure that fewer people suffer, or die prematurely, from heart disease, stroke and cancer by ensuring that access to NHS health checks for people between 40 and 74 that include and record all 10 key areas – age, gender, smoking, physical activity, family history, ethnicity, BMI, cholesterol, blood pressure and risk of diabetes, including appropriate follow up as necessary. We have set baselines and trajectories within the Operational Plan for each of the five key stroke metrics.

The current budget for acute services can support this agenda and release about £3m to support investment in other work streams through the shift from acute hospital based care to primary and community based services.

### 9.3.7 Long Term Conditions

The aim is to put in place joined up, co-ordinated, responsive and patient focused services for people with long term conditions (LTCs). Wherever possible, the services will be personalised, empowering, effective and integrated to ensure improvement in the quality of people’s lives.

**We will:**

• Focus on prevention through the identification of vulnerable groups, implementing smoking cessation and weight management programmes and targeting general prevention

• Ensure personal health plans for everyone with a LTC, starting with CHD and diabetes

• Introduce individual patient held budgets to support integrated more patient centred care. NHS Bedfordshire and the local authorities are part of a national ‘Staying In Control’ pilot

• Ensure information and support is available to patients 24/7 at the point of care and through the single point of contact. This will also ensure rapid access to community based services to avoid hospital admission when possible

• Further develop case management within primary care to support identified vulnerable people and ensure 24/7 support is available to maximise their health and minimise hospital admission. This will include timely access to diagnostics in primary care

• Further develop cardiac and pulmonary rehabilitation in the community

• Ensure comprehensive disease registers are in place for long term conditions

• We have set up a LTC steering group to oversee the delivery of our strategy. Membership includes representatives from local authority, carers, patients, secondary care, providers, third sector and PBC groups. Work streams have been set up to ensure that work is undertaken around the pathways related to LTC. These work streams have involvement from all members of the local health community and service users.
• This year we are focusing on the following conditions: diabetes, stroke rehabilitation, COPD, and Parkinson’s. We will ensure that we engage with people with these conditions.

The current programme budget for LTCs can support this agenda.

9.3.8 End of Life Care

The aim is to ensure all patients nearing the end of their life are empowered to make choices regarding their level of treatment, where they receive their treatment and their place of death. There is a strong focus on partner organisations working together to ensure that patients receive holistic assessment, that carer assessments are undertaken and that patients and carers feel supported in the choices that they make.

We will:

• Ensure end of life care is well co-ordinated and delivered seamlessly with the emphasis on improved communication. This will be supported by rapid access to 24/7 community services backed by specialist advice to enable patients to die at home, if that is their choice
• Raise awareness with the public about death and dying to encourage patients and families to discuss preferences and choices about treatment and place of death
• Ensure services, including GPs can deliver NICE supportive and palliative care and national End of Life Care quality measures
• Implement the End of Life Care clinical pathway across all relevant services. This covers: open and honest communication with patients and families; development of a care plan for the patient; assessment of carers needs; co-ordinated care across all settings; support for the patient in the dying phase; after death care and timely certification of death; and emotional and practical bereavement support
• Implement training and education programmes for all involved in End of Life Care. This includes emergency care staff to ensure they are able to support patient's choice
• Establish a Bedfordshire and Hertfordshire Palliative and End of Life Care network to support joint working and sharing best practice
• Ensure comprehensive disease registers are in place for long term conditions.

There is a need to invest in these services up to £1 million.
## 9.4 How We Will Measure and Monitor Progress

<table>
<thead>
<tr>
<th>Goal</th>
<th>Pledge</th>
<th>PCT Goals/outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer Premature Deaths</td>
<td>Life expectancy at time of birth, Years</td>
<td>Life expectancy at time of birth, Years</td>
</tr>
<tr>
<td></td>
<td>VSA 09 – Breast screening</td>
<td>VSA 09 – Breast screening</td>
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<tr>
<td></td>
<td>VSA 10 – Bowel cancer screening</td>
<td>VSA 10 – Bowel cancer screening</td>
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<tr>
<td></td>
<td>VSA 11, 12, 13 – Cancer</td>
<td>VSA 11, 12, 13 – Cancer</td>
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<tr>
<td></td>
<td>VSA 14 – Quality stroke care</td>
<td>VSA 14 – Quality stroke care</td>
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<td></td>
<td>VSB 01 – AAAC mortality</td>
<td>VSB 01 – AAAC mortality</td>
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<td>NI 120 – AAAC mortality(LAA)</td>
<td>NI 120 – AAAC mortality(LAA)</td>
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<tr>
<td></td>
<td>VSB 02 – CVD mortality</td>
<td>VSB 02 – CVD mortality</td>
</tr>
<tr>
<td></td>
<td>VSB 04 – Suicide &amp; injury</td>
<td>VSB 04 – Suicide &amp; injury</td>
</tr>
<tr>
<td><strong>Long term conditions</strong></td>
<td>Managing variation in emergency admissions calculated for a suite of 19 long term conditions’ Source: Better Care Better Value indicators NHS Institute for Innovation and Improvement</td>
<td>Managing variation in emergency admissions calculated for a suite of 19 long term conditions’ Source: Better Care Better Value indicators NHS Institute for Innovation and Improvement</td>
</tr>
<tr>
<td></td>
<td>% individuals with personal health plan against no on 19 LTC QOF registers:</td>
<td>% individuals with personal health plan against no on 19 LTC QOF registers:</td>
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<tr>
<td></td>
<td>QOF – annually</td>
<td>QOF – annually</td>
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<tr>
<td></td>
<td>VSB 02 – CVD mortality</td>
<td>VSB 02 – CVD mortality</td>
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<tr>
<td></td>
<td>VSB 03 – Cancer mortality</td>
<td>VSB 03 – Cancer mortality</td>
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<tr>
<td></td>
<td>VSB 04 – Suicide &amp; injury</td>
<td>VSB 04 – Suicide &amp; injury</td>
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<tr>
<td></td>
<td>VSC 15 – Death at home</td>
<td>VSC 15 – Death at home</td>
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<tr>
<td></td>
<td>VSC 20 – Emergency bed days</td>
<td>VSC 20 – Emergency bed days</td>
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<td></td>
<td>VSC 21 – ACS hospital admissions</td>
<td>VSC 21 – ACS hospital admissions</td>
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<tr>
<td></td>
<td>NI 141 – Vulnerable people</td>
<td>NI 141 – Vulnerable people</td>
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<tr>
<td></td>
<td>NI 130 – Independent living</td>
<td>NI 130 – Independent living</td>
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<tr>
<td></td>
<td>VSB 09 – Childhood obesity</td>
<td>VSB 09 – Childhood obesity</td>
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<tr>
<td></td>
<td>NI56 – Childhood obesity</td>
<td>NI56 – Childhood obesity</td>
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<tr>
<td><strong>Reducing Unfairness</strong></td>
<td>Average IMD (deprivation index) score</td>
<td>Average IMD (deprivation index) score</td>
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<tr>
<td></td>
<td>• LAA reduce the gap in life expectancy between the worst 20% and the best 20%</td>
<td>• LAA reduce the gap in life expectancy between the worst 20% and the best 20%</td>
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<tr>
<td></td>
<td>• Measure share across East of England reduce the gap in life expectancy between the worst 20% and the average</td>
<td>• Measure share across East of England reduce the gap in life expectancy between the worst 20% and the average</td>
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<tr>
<td></td>
<td>VSB 06 Maternity SVS</td>
<td>VSB 06 Maternity SVS</td>
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<tr>
<td></td>
<td>VSB 08 – Teenage pregnancy</td>
<td>VSB 08 – Teenage pregnancy</td>
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<tr>
<td></td>
<td>VSB 10 Immunisation</td>
<td>VSB 10 Immunisation</td>
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<tr>
<td></td>
<td>VSB 11 Breastfeeding 6-8 weeks</td>
<td>VSB 11 Breastfeeding 6-8 weeks</td>
</tr>
<tr>
<td><strong>Reduce Smokers</strong></td>
<td>No of quitters at four weeks: Vital Signs VSB05</td>
<td>No of quitters at four weeks: Vital Signs VSB05</td>
</tr>
<tr>
<td></td>
<td>Quarterly (also available monthly through Unify 2)</td>
<td>Quarterly (also available monthly through Unify 2)</td>
</tr>
<tr>
<td></td>
<td>NI 123 Smoking prevalence</td>
<td>NI 123 Smoking prevalence</td>
</tr>
<tr>
<td><strong>Marginalised groups and looked after children</strong></td>
<td>Percentage drug users recorded as being in effective treatment VSB 04 – Suicide &amp; injury</td>
<td>Percentage drug users recorded as being in effective treatment VSB 04 – Suicide &amp; injury</td>
</tr>
<tr>
<td></td>
<td>Monitoring recommendations from needs assessments of marginalised groups</td>
<td>Monitoring recommendations from needs assessments of marginalised groups</td>
</tr>
<tr>
<td><strong>Reduce childhood obesity</strong></td>
<td>Prevalence of obesity in year six Vital Signs VSB09</td>
<td>Prevalence of obesity in year six Vital Signs VSB09</td>
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<tr>
<td></td>
<td>Annual</td>
<td>Annual</td>
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<tr>
<td>Goal</td>
<td>Pledge</td>
<td>PCT Goals/outcome measures</td>
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<tr>
<td>Access to quality, safe clinically and cost effective local services.</td>
<td><strong>GP access</strong>&lt;br&gt;<strong>We will ensure GP practices improve access and become more responsive to the needs of all patients</strong></td>
<td>: &lt;br&gt;VSA06 – Access to GP – annually&lt;br&gt;VSA07 – Extended opening&lt;br&gt;Emergency readmissions: HCC Developmental Standard 1</td>
</tr>
<tr>
<td>Dentistry</td>
<td><strong>We will ensure NHS Primary Dental Services are available to all who need it</strong></td>
<td>Number/Proportion of population (adult and children) visiting an NHS dentist within the preceding 24 months Vital Signs VSB18&lt;br&gt;Source: NHS Dental Statistics for England&lt;br&gt;&lt;a&gt;<a href="http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry">http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry</a>&lt;/a&gt;&lt;br&gt;Quarterly</td>
</tr>
<tr>
<td>Access guarantees</td>
<td><strong>We will extend quicker access to our services</strong></td>
<td>VSA 04 – Elective care access&lt;br&gt;VSB 13 – Chlamydia screening&lt;br&gt;VSC 21 – ACS hospital admissions</td>
</tr>
<tr>
<td>Safety</td>
<td><strong>We will aim to make our healthcare system the safest in England</strong></td>
<td>Cases of C. Difficile per 10,000 population Vital Signs VSA03&lt;br&gt;Source: Health Protection Agency. Clostridium difficile infection surveillance data.&lt;br&gt;&lt;a&gt;Unify 2&lt;/a&gt;&lt;br&gt;<a href="http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx">http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx</a>&lt;br&gt;Office of National Statistics population estimates&lt;br&gt;&lt;a&gt;<a href="http://www.statistics.gov.uk/statbase/Product.asp?vlnk=601">http://www.statistics.gov.uk/statbase/Product.asp?vlnk=601</a>&lt;/a&gt;&lt;br&gt;Monthly&lt;br&gt;VSA01 – MRSA&lt;br&gt;Incident reporting: Standard 1 – quarterly&lt;br&gt;Medicines management: Standard 4d – half yearly&lt;br&gt;Record keeping: Standard 9 - annually&lt;br&gt;Reduction in hospital standardised mortality rate</td>
</tr>
</tbody>
</table>

Table 30 - Measures of progress against initiatives

We will also be developing monitoring and evaluation systems to ensure that initiatives and changes to services achieve the outcomes anticipated. If there is any variation from expected outcomes this will be investigated and corrective action identified.

9.5 Key Risks and Mitigating Actions

We have an effective assurance framework in place. It provides a simple but comprehensive method for the effective and focused management of identified principle risks that may prevent strategic objectives being met.

The Board Assurance Framework is underpinned by the other control mechanisms in place, such as the risk register and the declaration of compliance against the core standards in the
Healthcare Commission’s *Annual Health Check*. Action plans arising from the audit recommendations are monitored by the Audit Committee.

A summary of key risks to delivery of the initiatives and mitigation of these risks are set out in table below.

### 9.5.1 Most Critical Executive / PCT Level Risks

<table>
<thead>
<tr>
<th>ID</th>
<th>Initiative Impacted</th>
<th>Risk</th>
<th>Impact (1-5)</th>
<th>Likelihood (1-5)</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| 1  | All                 | NHS Beds losing the capacity and capability across the organisation to deliver our initiatives. | 4 | 2 | • Recruit into vacant posts.  
• Bring in skills and capabilities via Third party resources and fixed term contactors. |
| 2  | All                 | Insufficient funding after year 1 to deliver strategic initiatives (especially pertinent given current financial constraints). | 4 | 3 | • Clear prioritisation and maintain strong financial management.  
• Focus on cash releasing savings from within current spends. |
| 3  | All                 | Failing to gain clinical and public engagement with initiatives due to lack of resource. | 4 | 2 | • Communication & Engagement strategy. |
| 4  | All                 | Ability to successfully stimulate the local market. | 4 | 2 | • Filling vacant posts in structure.  
• Deliver on WCC competencies. |
| 5  | All                 | IT infrastructure not fit for purpose. | 4 | 3 | • Review current service level agreements in place.  
• Identify IT requirements.  
• Buy in expertise where necessary. |
| 6  | All                 | Estate not fit for purpose. | 4 | 2 | • Review of current real estate.  
• Model future requirements.  
• Implement estate strategy. |
| 7  | All                 | Insufficient capacity and capability of workforce across NHS Beds and providers. | 4 | 2 | • Implement OD strategy. |

Table 31 – Most critical executive / PCT level risks

### 9.5.2 Most Critical Initiative Risks

<table>
<thead>
<tr>
<th>ID</th>
<th>Initiative Impacted</th>
<th>Risk</th>
<th>Impact (1-5)</th>
<th>Likelihood (1-5)</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| 8  | Staying Healthy     | Local Government reorganisation and formation of two new unitary authorities may impact on health care rating. | 3 | 3 | • Work closely with two new unitary authorities to ensure a co-ordinated approach across health.  
• Agreement has been made that the director of public health post will be a jointly funded post across NHS Bedfordshire and the new unitary authorities. |
| 9  | Staying Healthy     | Over activity in acute and demand lead services. | 4 | 2 | • Strengthen primary and secondary prevention which will have an impact on acute and demand led services. |
| 10 | Mental Health, including drug users | Failure to ensure we have the correct staff skill mix to provide our IAPT primary care work plan. | 4 | 2 | • Review of current skills in organisation.  
• Focused recruitment campaign. |
<table>
<thead>
<tr>
<th>ID</th>
<th>Initiative Impacted</th>
<th>Risk</th>
<th>Impact (1-5)</th>
<th>Likelihood (1-5)</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Failure to redirect investment from secondary settings.</td>
<td>3</td>
<td>2</td>
<td>• Detailed service re-design programme.</td>
</tr>
<tr>
<td>11</td>
<td>Mental Health, including drug users</td>
<td>Increase in drug using offenders impacting the local community.</td>
<td>4</td>
<td>3</td>
<td>• Identification of increased mainstream funding for drug treatment.</td>
</tr>
<tr>
<td>13</td>
<td>Maternity &amp; Newborn</td>
<td>Unable to fund, as new initiatives as they provide limited short term financial returns.</td>
<td>3</td>
<td>3</td>
<td>• Ensure extra investment underpinned by robust service specifications and quality schedules with acute providers, in order to assure that the PCT would receive value for money from these extra funds.</td>
</tr>
<tr>
<td>14</td>
<td>Maternity &amp; Newborn</td>
<td>Providers unable to recruit sufficient midwives.</td>
<td>4</td>
<td>2</td>
<td>• The PCT has responsibility for co-ordinating county-wide workforce planning. A detailed action plan to support this area of work is due for completion by April 2009, and whole-systems work is already underway locally and regionally to address these challenges.</td>
</tr>
<tr>
<td>15</td>
<td>Children's services</td>
<td>Workforce issues may cause some staffing difficulties.</td>
<td>3</td>
<td>3</td>
<td>• Involve HR at early stage.</td>
</tr>
<tr>
<td>16</td>
<td>Children's services</td>
<td>Initiative will rely heavily on the new unitary authorities sharing the vision and priorities with the NHS.</td>
<td>3</td>
<td>3</td>
<td>• Work closely to engage unitary authorities, promoting joint commissioning, funding, and planning.</td>
</tr>
<tr>
<td>17</td>
<td>Planned care, including dental</td>
<td>Successful delivery of this strategy can only be achieved through collaboration with all partners.</td>
<td>3</td>
<td>2</td>
<td>• Work closely with clinicians and colleagues across primary &amp; secondary care, East of England, local authorities, the voluntary sector and individual carers / users to make it happen.</td>
</tr>
<tr>
<td>18</td>
<td>Planned care, including dental</td>
<td>Standard of acute care may fall as funding / activity diverted to community settings.</td>
<td>4</td>
<td>2</td>
<td>• Work closely with acute providers to manage migration of care settings.</td>
</tr>
<tr>
<td>19</td>
<td>Dentistry</td>
<td>Key risk is that we will not meet targets for population in very north of the county, because the sparsely populated area will not provide sufficient work to support local dental practices.</td>
<td>4</td>
<td>2</td>
<td>• Close monitoring and support for the development and maintenance of practices on the borders of the rural areas. • If this fails then mobile provision may be needed, and possibly a service model that includes the PCT provider service or any successor.</td>
</tr>
<tr>
<td>20</td>
<td>Acute care</td>
<td>Lack of resources to deliver urgent care centre.</td>
<td>4</td>
<td>2</td>
<td>• Resource identified within growth. • Capital investment programme in primary care.</td>
</tr>
<tr>
<td>21</td>
<td>Safety</td>
<td>C diff causes rise above upper threshold compromising patient safety. Financial penalty would impact ability to deliver high patient experience.</td>
<td>5</td>
<td>1</td>
<td>• Closely associated monitor key performance indicators and metrics.</td>
</tr>
<tr>
<td>22</td>
<td>Long term conditions</td>
<td>Increase demand.</td>
<td>4</td>
<td>2</td>
<td>• Demonstrate flexibility and adaptive commissioning approach to ensure there is sufficient provision.</td>
</tr>
<tr>
<td>ID</td>
<td>Initiative Impacted</td>
<td>Risk</td>
<td>Impact (1-5)</td>
<td>Likelihood (1-5)</td>
<td>Mitigation</td>
</tr>
<tr>
<td>----</td>
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<td>------------</td>
</tr>
<tr>
<td>23</td>
<td>Long term conditions</td>
<td>Pace of change is too slow.</td>
<td>4</td>
<td>3</td>
<td>• Ensure dedicated project management / external support if necessary.</td>
</tr>
<tr>
<td>24</td>
<td>End of life care</td>
<td>The number of additional staff identified by the community service teams maybe under estimated.</td>
<td>3</td>
<td>2</td>
<td>• Processes for monitoring and reporting, on a regular basis, increases in the clinical lists for the community nursing disciplines.</td>
</tr>
<tr>
<td>25</td>
<td>End of life care</td>
<td>The number of SPC and respite bed palliative care provision may need to be reviewed and increased.</td>
<td>3</td>
<td>3</td>
<td>• Regular monitoring and reporting the increase in referrals for SPC and respite beds. • Audits on reasons for referral.</td>
</tr>
<tr>
<td>26</td>
<td>End of life care</td>
<td>Independent care homes ability to recruit and retain staff that have End of Life Care skills and training.</td>
<td>3</td>
<td>2</td>
<td>• Implement sustainable permanent training programmes that link to university or college recognised qualifications.</td>
</tr>
</tbody>
</table>

Table 32 – Most critical initiative risks

9.6 Links to Underpinning Plans

This section sets out key plans that underpin the successful delivery of our strategy:

- Practice based commissioning operational framework. Appendix G
- Communications and public engagement strategy. Appendix H
- Workforce and organisational development plan. Appendix I
- Information management and technology strategy. Appendix J
- Capital and estates.

9.6.1 Communications and Public Engagement

The Communications and Engagement Strategy sets out how NHS Bedfordshire will communicate, involve and manage relationships with all of its stakeholders, including patients, carers, members of the public, staff, service providers, partners, the media and others. NHS Bedfordshire will

- Ensure that communication and engagement is both planned and linked to the trust’s aim, goals and strategic priorities as expressed in A Healthier Bedfordshire
- Support the development of NHS Bedfordshire as a high performing, patient centred commissioning body, as described by the World Class Commissioning (WCC) Framework
- Set out progress to date in the development of our communications and engagement capacity and capability
- Set out and prioritise communication and engagement objectives to ensure that consequent activities are realistic and deliverable within current resources.
9.6.2 Workforce

It is critical that we have the capacity and capabilities within our workforce and external provider partners to deliver upon our strategic initiatives.

Internal Capability Requirements

At an executive level, to deliver the strategic plan and the goals which will achieve this we will need to ensure our people have world class skills in a wide range of competencies, including:

- Strong leadership and direction, ensuring that the vision we set out in this plan is communicated and acted upon throughout the organisation
- Commissioning/contract management.
- Market management
- Project management
- Information analysis and trend analysis
- Financial / budgetary control
- Ability to monitor progress of initiatives and plan interventions where necessary.

We need to lead the development of the skills of managers and clinicians in the health system and ensure collaborative working is effective with providers and other partners, including patients. Systems have been established to undertake this work including the County Workforce Group, which will lead on our strategic system wide workforce planning. We have created additional capacity and expertise in this area and will continue to work closely with the Workforce Directorate at the East of England to enable integrated strategic workforce planning to take place. During 2009/10, the County Workforce Group is developing and agreeing a 3-5 year local strategic workforce plan and will ensure local stakeholders are involved in the development of these plans.

Key Workforce Requirements at Initiative Level

<table>
<thead>
<tr>
<th>Initiative Area</th>
<th>Workforce Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying Healthy</td>
<td>• Increase the health promotion and health advisory capabilities of all staff. In the past, there has not been a clear career path for the development of public health and health improvement specialists and this needs to be addressed.</td>
</tr>
<tr>
<td></td>
<td>• The role of health trainers and support roles need to be developed to enable people and patients to make healthier choices.</td>
</tr>
<tr>
<td></td>
<td>• The health visitor and school nurse development needs to be changed to reflect the increased health improvement role they will take on. These roles will be in primary care, community services and hospital based services.</td>
</tr>
<tr>
<td>Initiative Area</td>
<td>Workforce Requirement</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental Health, including drug users</td>
<td>- The workforce developments in mental health will need to support the improved delivery of mental health care in primary care, with projects such as an integrated approach to psychological therapies (IAPTs) and the development of primary care mental health workers.</td>
</tr>
<tr>
<td></td>
<td>- Psychological therapy staff is already an area of shortage and population increases indicate a need to increase the number of staff.</td>
</tr>
<tr>
<td></td>
<td>- Reviews of acute mental health and dementia services required.</td>
</tr>
<tr>
<td></td>
<td>- There is a need to increase the knowledge in primary care regarding drug use and referral to the specialist services.</td>
</tr>
<tr>
<td>Maternity and New Born</td>
<td>- We need to recruit and retain more midwives, to increase capacity in community midwifery services and to increase the capacity for antenatal scanning and postnatal support, including breast feeding based around children’s centres.</td>
</tr>
<tr>
<td></td>
<td>- There are also concerns about the level of medical support available in this specialty and the training time to develop more medical specialists.</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>- Need to recruitment around speech and language therapy and occupational therapy posts.</td>
</tr>
<tr>
<td></td>
<td>- Increased use of rotational schemes for post qualified therapists to increase expertise in paediatric services in mental health, learning disabilities and physical disabilities.</td>
</tr>
<tr>
<td></td>
<td>- The training for health visitors and school nurses will be reviewed to develop a modular based programme, including the skills identified through this indicator. The role and effectiveness of health trainers will also be explored.</td>
</tr>
<tr>
<td>Planned Care including Dental</td>
<td>- Workforce analysis and planning needs to focus on identification of workforce competencies from the Health Needs Assessment, the development of appropriate training programmes including non medical prescribing and management of long term conditions, and the development of self care programmes for patients which will impact on their expectations of the workforce.</td>
</tr>
<tr>
<td></td>
<td>- There are high vacancy levels amongst many of the specialist needed to ensure the delivery of these targets and this will need to be addressed in robust workforce planning and development.</td>
</tr>
<tr>
<td></td>
<td>- The increasing population in Bedfordshire will impact on the need to develop, recruit and retain more staff working in dentistry.</td>
</tr>
<tr>
<td>Acute Care</td>
<td>- A review of care pathways over the next two years will enable the development of a workforce plan to accommodate the required change in focus (i.e., more critically ill patients).</td>
</tr>
<tr>
<td></td>
<td>- The will be a review of care pathways over the next two years.</td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td>- Education and training for existing and future staff (clinicians, support workers, reception staff and social care workers) will ensure professionals have the 7 Core Common Principles/competencies to support self care.</td>
</tr>
</tbody>
</table>
The roles of GPs and community matrons will need to be reviewed and developed to support the care pathway.

Likely impacts will be on the development of community based staff to provide 24/7 care and support as well as enhanced advice and support to a larger number of patients.

There will also be a need to review the impact in primary care and improve the skills and knowledge of staff to support the increase of patients wishing to stay at home.

Table 33 - Workforce requirements at initiative level

The workforce implications of the strategy have been reviewed in further detail and the workforce risk areas and levers for change have been identified.

These will be used by the initiative leads to facilitate change to achieve our strategic aims.

Heat maps – An overview of the change to the workforce

A Healthier Bedfordshire - Workforce Implications

Table 34 - Workforce requirements at initiative level
Health System Capability Gaps

To ensure we have the relevant skills within our organisation, we have developed a countywide programme lead and workforce planning post. We will work with providers and other partners in the system to ensure integrated workforce planning and development takes place.

The timetable and process for developing our health system workforce plan is:

- **October 08** Darzi care pathway workforce identification workshop, involving commissioners, clinicians and managers, as well as workforce planning leads
- **November 08** Workforce planners and service leads review workforce figures to realign with care pathways and priorities
- **December 08** First draft workforce plan and education commissioning plans produced
- **March 09** Interim workforce plan linked to NHS Bedfordshire strategy
- **May 09** System wide review of workforce plan involving commissioners, clinicians and managers and local authority leads
- **October 2009** More detailed revision of the workforce plan to ensure links to education commissioning clear
- **March 2010** Health system talent and leadership plan including clinical leadership for implementation from April 2010.

New Ways of Working

Many of the new service models across the clinical pathway groups will require changes to existing roles and / or the introduction of new roles. There are risks associated with the time taken to develop and implement new roles or to make changes to existing staff functions. Areas of risk include: lead in time for the development and validation of curricula; access to appropriate clinical placements and supervision; and wider fit to multi disciplinary team approach.

Demographics

Regional workforce demographic data show there are current shortages of staff in the following areas:

- General practice.
- Primary and community nursing (specialist versus generalist roles).
- Pharmacists
• Shortages of NHS orthodontist specialist and trainers for practitioners.

In addition, local intelligence identifies shortages in the following areas:

• Paediatric occupational therapists
• Midwifery
• Health care scientists.

There are also anticipated shortages through retirement and an ageing workforce which could pose risks to the delivery of our strategy.

The integrated workforce plan will address how the local health system will overcome these shortages through role redesign, recruitment and retention strategies.

**Education Curricula**

In order to deliver new roles and functions, changes to training curricula will need to take place. This is equally important for the continuing professional development of the existing workforce to support delivery of the *Improving Lives: Saving lives* pledges over the next three years, as well as pre-registration programmes. Key themes arising from the risk assessments identify the following risks;

• The capacity for clinical placements
• Non medical prescribing
• Enhancing clinical leadership
• Education curricula for bands 1-4
• Enhancing education needs for patients and carers via programmes such as Expert Patients and Carers programmes.

We will work closely with local higher education and further education providers through the county workforce structure to ensure the necessary changes to training curricula take place.

**Talent and Leadership Development**

The County Workforce Group is in the process of agreeing and implementing a talent and leadership plan for the health system. This will ensure that there is strong leadership, both clinical and non clinical, throughout organisations to ensure successful delivery of our strategy.

**People and Process**

Within NHS Bedfordshire, competence to deliver better health outcomes to the people of Bedfordshire will be developed through the implementation of World Class Commissioning. The organisation has already realigned its functions and is currently increasing its capacity in line with the World Class Competencies. Management and
reporting systems will work in a matrix management structure around care pathways and programme budgets in order that contracts can be agreed with providers and performance managed to meet the goals of NHS Bedfordshire.

**Bedfordshire Health System**

We will continue to develop effective partnership working arrangement with key stakeholders through a variety of mechanisms. The changes in local government in April 2009 have resulted in strengthened joint strategic planning arrangements in the two new unitary authorities: Central Bedfordshire Healthier Communities and Older People Partnership Board; Bedford Borough Health and Wellbeing Partnership Boards; and ‘Be Healthy’ groups for Bedford Borough and Central Bedfordshire. These are underpinned by the executive groups Joint Strategic Needs Assessment. We have restructured to increase the leadership available to facilitate and lead service redesign across the system, engaging with our partners, patients and public.

### 9.6.3 Information Technology

NHS Bedfordshire has a system wide IM&T plan which identifies the various IT systems and processes that we will be putting in place across the health system to underpin the delivery of our strategy. Our key responsibilities are:

- Providing overall leadership and direction to the local health system for the IM&T programme
- Establishing an IM&T programme as an enabler of overall ‘service transformation’ for the local health community – service change, not just IM&T implementation
- Ensuring realisation of benefits from the IM&T programme which, together, ensure local health community achieves its desired outcomes in terms of service change
- Establishing governance structures and processes required to support the effective management of an IM&T programme ‘aligned’ local health community’s service change programme
- Ensuring the local health community has an effective and transparent approach to risk management
- Ensuring the local health community has the capacity and capability to resource the programme including change management, not just IM&T delivery
- Ensuring the local health community has a clear and transparent framework for prioritisation, approval and funding of projects within the programme
- Supporting all the functions of NHS Bedfordshire, with a fit for purpose corporate IT infrastructure, as it becomes a world class commissioning organisation
- Managing the IM&T implications of the transition of community services.

Our IM&T plan details how we are addressing each of the above areas and what the key IM&T enablers are for the different clinical care pathways. See appendix J.
9.6.4 Capital and Estates

In order to respond to our four strategic goals:

A new direction for health in capital and estates is required in Bedfordshire, with our three strategic priorities defined as:

1. **Prevention**
   Investing a greater proportion of our money into prevention.

2. **Care closer to home**
   Creating effective support in local communities to reduce the reliance on hospital care. *A Healthier Bedfordshire* aims to provide services that are ‘local where possible, central where necessary’. The range of services is designed to ameliorate long term conditions such as diabetes, asthma and coronary heart disease, and to manage the condition to avoid complications resulting in emergency admission to hospital. The strategy is to move traditional hospital based services into district or local centres closer to home. This will allow the hospitals to concentrate and develop a wider range of more complex specialist services which will offer patients improved choices and reduce the need for referrals outside Bedfordshire. This strategy will increase the ability to expand in line with the forecast population growth.

3. **Choice and Convenience**
   Offering more choice and convenience, based on patients’ needs and preferences.

Wealth and health are unevenly distributed across Bedfordshire. The least deprived Medium Super Output Areas (MSOA) in Bedfordshire broadly equate to the following electoral wards:

- Ampthill
- Aspley Guise
- Bromham
- Clifton and Meppershall
- Cranfield
- Flitwick West
- Flitton Greenfield and Pulloxhill
- Harlington
- Shefford Campton and Gravenhurst
- Silsoe
- Southcott
- Shillington Stndon and Henlow Camp
- Stotfold
- Watling
- Westoning and Tingrith
The most deprived MSOAs in Bedfordshire broadly equate to the following electoral wards:

- Castle
- Cauldwell
- Goldington
- Harpur
- Kempston North
- Kempston South
- Kingsbrook
- Manshead
- Parkside
- Queens Park
- Tithe Farm

Health inequalities are driven by differences in high risk lifestyle behaviours such as smoking, obesity and physical inactivity; variations in access to healthcare; and by wider socio-economic factors, such as poverty, housing, employment and the built environment.

In Bedfordshire, wards and MSOAs are almost the same. We have identified the 20% most deprived wards and have set up a dashboard to monitor uptake of services and interventions, for example, flu and counterweight. NHS Bedfordshire has enhanced smoking targets for the 20% most deprived areas and will ensure that all interventions focus specifically on them.

Inequalities not only relate to deprivation and where you live; some members of our society experience inequalities more than others. There are complex reasons why people can become marginalised. Within Bedfordshire, with our partners we have identified the following groups as at risk of being marginalised:

- People who misuse drugs and alcohol
- People with mental ill-health, including dementia
- People with long-term conditions or disabilities
- People from black and minority communities
- Homeless and rough sleepers
- Those in the criminal justice system, including young offenders
- Gypsies and travellers
- Looked after children
- Pregnant teenagers and their children
- Migrant workers and refugee communities.

NHS Bedfordshire is in the process of developing a new estates strategy that will respond to emerging service strategies and allow commissioners the flexibility to manage a dynamic provider market, in particular around local services.

The majority of the facilities available for NHS services in Bedfordshire have historically been controlled by service providers. The Board of NHS Bedfordshire has
resolved to move increasingly towards taking direct control over key strategic estates and locations.

In each case, a commissioning-led approach will be taken to identifying and securing appropriate capacity for the provision of local services. We have identified 14 strategic countywide community / locality priorities, as shown below:

Figure 22 – Priority strategic localities

1. Bedford North / Town Centre
2. Bedford South
3. Kempston
4. Sandy
5. Biggleswade
6. Wixams
7. Ampthill
8. Flitwick
9. Leighton Buzzard
10. Linslade
11. Houghton Regis
12. Dunstable North
13. Dunstable Town Centre
14. Station Quarter
The anticipated shift of services out of the hospital sector needs to be mapped geographically, linked to the known shortfalls in capacity for existing community services, to develop a clear set of commissioning-led requirements for strategic estate within local communities.

NHS Bedfordshire is a core member of the Assemble Community Partnership LIFT Company. We will use the partnership (which also includes Milton Keynes PCT and East and North Hertfordshire PCT) to maximise the benefits of working across the public and private sectors and as a delivery vehicle for change that can catalyse refurbishment and development of estate.

The planned growth of the local population is described in detail in Chapter 2 in relation to patient numbers and demography. However, it is important to also note that the impact of the geographic nature of this growth on the local capacity to deliver services is modelled on a locality by locality basis.

**Planning for New Services**

As plans emerge to invest in building capacity in the community for a wider range of services, including those moving out of the hospital sector, the requirements to deliver planned care within local communities need to be described in terms of the populations they will serve.

This geographic modelling of services is needed to inform the subsequent estates requirement within localities and thus the commissioning of facilities for health care. It also needs to take account of parallel planning of other local services such as children’s centres, extra-care housing and social care. Examples emerging include:

- **Staying Healthy:** Lifestyle support services need to be integrated, well publicised and easy to access.
- **Mental Health (including drug users) and Learning Disabilities:** Reduce the number of acute inpatient beds, but provide them in a better quality and more therapeutic environment. Commission, a modern pattern of day care services, in line with ‘Valuing People’ principles.
- **Children’s Services:** 30% of planned services currently delivered in acute settings are shifting to the community, resulting in 1,860 additional appointment slots in Bedfordshire.
- **Long term conditions:** 65% of current hospital-based outpatient appointments are for people with long term conditions. Over the next five years, people will be treated sooner and nearer to or at home.
- **Planned Care:** Shift 40% of outpatient appointments; 60% of minor planned surgery and 20% of non complex planned medicine into the community. Commission community based diagnostic services, intermediate care centres and integrated rehabilitation and treatment services.
The estates strategy for NHS Bedfordshire will need to explore the detailed thinking behind service development plans in the key areas identified above to take forward local planning for facilities and estates.

9.7 Change Management

In order to implement the strategy and achieve the health outcomes for the people of Bedfordshire, extensive service redesign will need to take place across the system.

This will involve partners, providers, patient and public representative groups to ensure the changes in services and in the way the services are provided have the support of all stakeholders. This will also involve identifying potential new providers.

At the core of the change and service redesign will be the vision, values and goals of NHS Bedfordshire and the intentions detailed in the care pathways. We will drive the change required across the local health system by continuing with our strong performance management culture and by holding our providers to account. We recognise that a major part of this will be ensuring that effective clinical leadership is in place, both within NHS Bedfordshire and across the local health system.

NHS Bedfordshire will invest in change management expertise to implement sustainable change, retaining staff in the health system with skills, expertise and enthusiasm for improving health and providing care locally.

We have recently reviewed and implemented our internal structures to ensure that clinical service redesign capability is strengthened within our health system management function. This function will lead and develop pathway redesign groups as the major change vehicle to bring together commissioners, clinicians, providers and patient/public representatives to advise the commissioners on service change and specifications. These groups will be supported by Finance, Workforce, IM&T, Estates, and Public Engagement and Communication, as appropriate, to ensure effective matrix working across NHS Bedfordshire. The groups will provide strong change management leads to work with providers to enable sustainable change to take place. This will mean that we will be developing some internal capability in this area as well as purchasing expert specialist support when required. These groups will follow a systematic process for managing change and changing behaviours.

We recognise the importance of actively engaging with patients and the public to understand their needs and to help them help us design services in the most satisfactory way. Therefore, we will ensure that the views of patients and public are built into the commissioning cycle. In order to do this, we have created a dedicated public engagement and communications directorate and are in the process of increasing capacity and expertise in this area. This will enable us to provide enhanced advice and practical support to the care pathway redesign groups, utilising a broad range of engagement and involvement activities. These include service user representation and participation on key groups; focus groups; formal statutory consultations; patient surveys; deliberative events and other market research methodologies to monitor and evaluate patient experience.
Identifying and managing changes needed in the workforce and making these changes happen will be an integral feature of the work of the pathway redesign groups. To achieve this, we have established and are leading the Bedfordshire County Workforce Group, with representatives from clinicians, service providers, social care, higher and further education, Learning Skills Council, Skills for Health and staff representatives. The group will develop and align the local health system workforce plan to our service and financial strategies to ensure that resources are invested appropriately. This will also ensure that we are able to commission the appropriate education and training for the local health system.

All of this work will be underpinned by working in partnership with staff and their representatives to deliver change sensitively, providing appropriate time, access and support for training and development.

During 2009/10, the County Workforce Group is developing and agreeing a 3-5 year local strategic workforce plan and will:

- Ensure that local stakeholders are involved in the development of these plans
- Ensure that resources delegated to the group are invested wisely and that excellent governance arrangements are in place
- Develop a talent management and capability plan that identifies and develops more leaders across the local health system
- Develop and discuss strategies for improving staff satisfaction and engagement.

Having set up a knowledge management function within NHS Bedfordshire, this will act as a key lever for change across the system as it will enable us to use information and intelligence to identify our priority areas for action and to benchmark our services. In addition, this function will enable us to ensure better data quality which, in turn, will lead to evidence based decision making.
10 Appendices

A. Initiatives
B. Towards The Best Together, Mental Health Implementation Plan
C. Operational Plan
D. JSNA
E. Performance Report
F. Prioritisation Policy
G. PBC Operational Framework
H. Communications and Engagement Strategy
I. Organisational Development Plan
J. IM&T Strategy
K. Equalities Impact Assessment
L. Primary Care Strategy
M. East of England Check List